

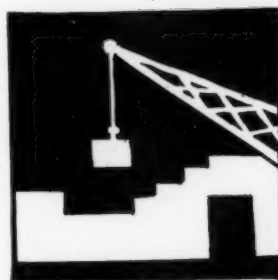
JUNE 1957

American Psychiatric Association

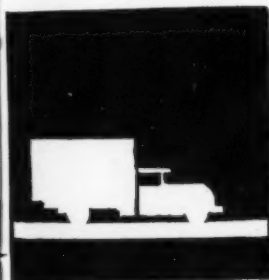
Mental Hospitals



FARM



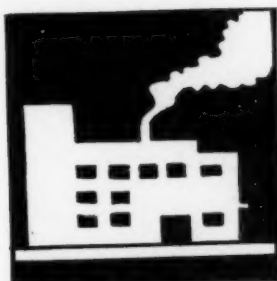
CONSTRUCTION



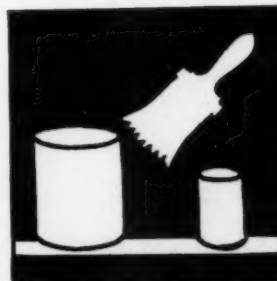
PROCUREMENT



FINANCE



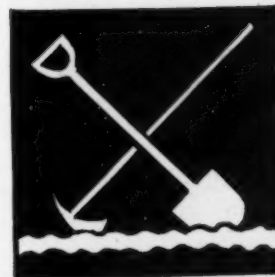
LAUNDRY



PAINTING



REPAIR



GROUNDS CARE

**BUSINESS ADMINISTRATION
SUPPLIES THE SERVICES**

tions
ne as
pos-
mple,
hotic
all of
what
eling
how
is re-

peri-
we
enda-
believe
any
ll be
it is
ishes,
quality
than

press
ould
apture
e pa-
nd to
ishes,
erson-

choice
we
ovide
matic
at an-
matter

pro-
Small
ing in-
pri-
seem
f this

small,
build-
ssages
hieve
a fa-
ation,
pose-
e out-
ient's
differ-
cour-
level-
sonal

A.I.A.



TO GET THROUGH TO THE PATIENT

SPARINE controls acute psychotic agitation without dulling mental acuity—thus inducing the calm accessibility so essential to psychotherapeutic rapport.

SPARINE is also highly effective in drug addiction and alcoholism for the control of withdrawal symptoms.

SPARINE is a well-tolerated and dependable agent when used according to directions. It may be administered intravenously, intramuscularly, or orally. Parenteral use offers (1) minimal injection pain; (2) no tissue necrosis at the injection site; (3) potency of 50 mg. per cc.; (4) no need for reconstitution before injection.

Professional literature available upon request.

•Trademark

Sparine

Promazine Hydrochloride

10-(γ -dimethylamino-n-propyl)-phenothiazine hydrochloride

Wyeth

Philadelphia 1, Pa.

Publ
of m
can
of \$
\$50
(for
dues
soci
the
Aver
1st,

A.P.
Har
Wil

ME
Wi
R.
Har
M.I.
Rap
Me

ME
Dar
Rol
Ch
Ch
Ga
Au
Ad
Ad
N.

CONTENTS, JUNE 1957

Articles

THE TWENTY-FOUR HOUR CARE OF THE PATIENT	Harry C. Solomon, M.D.	3
HOSPITAL ADMINISTRATION AND THE MEDICAL SUPERINTENDENT	Daniel Blain, M.D.	6
HOW THE MENTAL HOSPITAL BUDGET LOOKS TO THE LEGISLATOR	Senator J. R. Hall, Jr.	14
COMPREHENSIVE INSURANCE COVERAGE FOR HOSPITALS	Lawrence E. Kefer	18
LOCKS AND KEYS	Aaron S. Mason, M.D.	26
SAFETY PROGRAM REDUCES ACCIDENTS	H. F. Townsend	36
A HOUSEKEEPER SHARES HER EXPERIENCES	Helen K. Johnson	37
SPECIFICATIONS—AN AID TO PURCHASING	B. R. Cheyney	43
ACCURATE COST ACCOUNTING	Warren E. Lester	44
CARE OF THE PATIENT'S PERSONAL EFFECTS AND CLOTHING	Alexis Tarumianz	48
MENTAL HOSPITAL SANITATION	E. Calvin Moore, M.D.; Walter C. Baker	49

Architectural Supplement

PREVENTIVE MAINTENANCE BEGINS WITH DESIGN	Albert Millar, Jr.	29
PLANNING AN EFFICIENT LAUNDRY DEPARTMENT	A. L. Christensen; Lee G. Johnston	32

Special Features

M.H.S. Salutes Austin M. Davies		5
1957 M.H.S. Achievement Award Winners		13
Look in the Broom Closet, Doctor	Dr. Whatsisname	24
Departments		38
Preliminary Program Topics for Ninth Mental Hospital Institute		46

Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Subscription prices: At the rate of \$2.50 a year each, up to 15 copies of each issue are included in the dues of \$50 a year for institutional subscribers to the Service. Individual subscription rate (for staff members of subscribing institutions only) \$2.50 a year. Limited-service dues of \$15.00 a year for related professional organizations and mental hygiene societies include 5 copies of each issue at the rate of \$2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Entered as Second Class mail matter, August 1st, 1952, at the Post Office, Washington, D. C., under act of March 3, 1879.

A.P.A. OFFICERS:

Harry Solomon, M.D., Pres.; Francis J. Gerty, M.D., Pres.-Elect; William Malamud, M.D., Secy.; Jack Ewalt, M.D., Treasurer.

MENTAL HOSPITAL SERVICE CONSULTANTS:

Winfred Overholser, M.D., Chief Consultant; Mr. Carl E. Applegate; R. A. Chittick, M.D.; Mr. R. Bruce Dunlap; Addison M. Duval, M.D.; Harrison Evans, M.D.; William L. Jaquith, M.D.; Granville L. Jones, M.D.; Mr. Robert H. Klein; Margaret E. Morgan, M.D.; Walter Rapaport, M.D.; Charles A. Roberts, M.D.; Harvey J. Tompkins, M.D.; Mesrop A. Tarumianz, M.D.; Gale H. Walker, M.D.

MENTAL HOSPITAL SERVICE STAFF

Daniel Blain, M.D. Director & Editor of MENTAL HOSPITALS. Robert L. Robinson, M.A. Exec. Assoc. **Editorial Dept.:** Pat Vosburgh, Chief, Elizabeth A. Keenan. Advised by: Ralph M. Chambers, M.D.; Charles K. Bush, M.D., Chief; Frederick L. McDaniel, M.D.; David C. Gaede, M.D.; Dorothy M. Richardson, A.P.A. Central Inspection Board; Austin Davies, Ph.B., A.P.A., Exec. Asst., & Contributing Editors. **Advertising & Promotion:** Phyllis Woodward, L.L.B.; **National Advertising Representative:** Fred C. Michalove, 6 East 39th Street, N. Y. 16 (Murray Hill 5-6332).

(Cover Design by George Paterson)

BUSINESS ADMINISTRATION SUPPLIES THE SERVICES

This issue of MENTAL HOSPITALS, the first of its kind, is dedicated specifically to the army of people—some 60,000 or more—whose work, while it is not concerned with direct patient treatment, is concerned with their most basic physical needs—food, shelter, clothing, hygiene and comfort.

This will not be the only issue of the magazine to carry material on engineering, maintenance, house-keeping, accounting procurement, sanitation, budgeting and the like. It is, we hope, but a beginning. Each month some part of MENTAL HOSPITALS will be devoted to these and similar matters.

This particular issue of MENTAL HOSPITALS will reach approximately 1,500 people working in mental hospitals who are unfamiliar with the magazine. Unfortunately at the present time it is not possible for us to send a personal copy each month to each one of these welcome new readers. But a copy of each current issue will be found in the hospital library and we hope that our new readers will make a practice of seeing it there until we can do something more positive about reaching them personally.

TO "NORMALIZE" THE THINKING PROCESSES*

AN ADVANCE in the treatment of mental and emotional disorders, Pacatal overcomes many of the disadvantages inherent in the earlier phenothiazine compounds.

TRANQUIL, YET RESPONSIVE:

With Pacatal, patients are calmed, yet they remain alert, active and cooperative. Pacatal does not "flatten" the patient.

FEWER SIDE EFFECTS:

Pacatal has fewer side effects at recommended dosage levels. Atropine-like effects may occur in some patients, but tend to disappear with continued therapy.

DOSAGE: Usual dosage for the ambulant patient is 25 mg. 3 or 4 times daily; for the hospitalized patient, 50 mg. 3 or 4 times daily. *Complete literature and dosage instructions (available on request) should be consulted.*

SUPPLIED: 25 and 50 mg. tablets in bottles of 100 and 500. Also available in 2 cc. ampuls (25 mg./cc.) for parenteral use.

**Many investigators report that Pacatal seems to have a "normalizing" action, i.e., patients appear to think and respond emotionally in a more normal manner.*

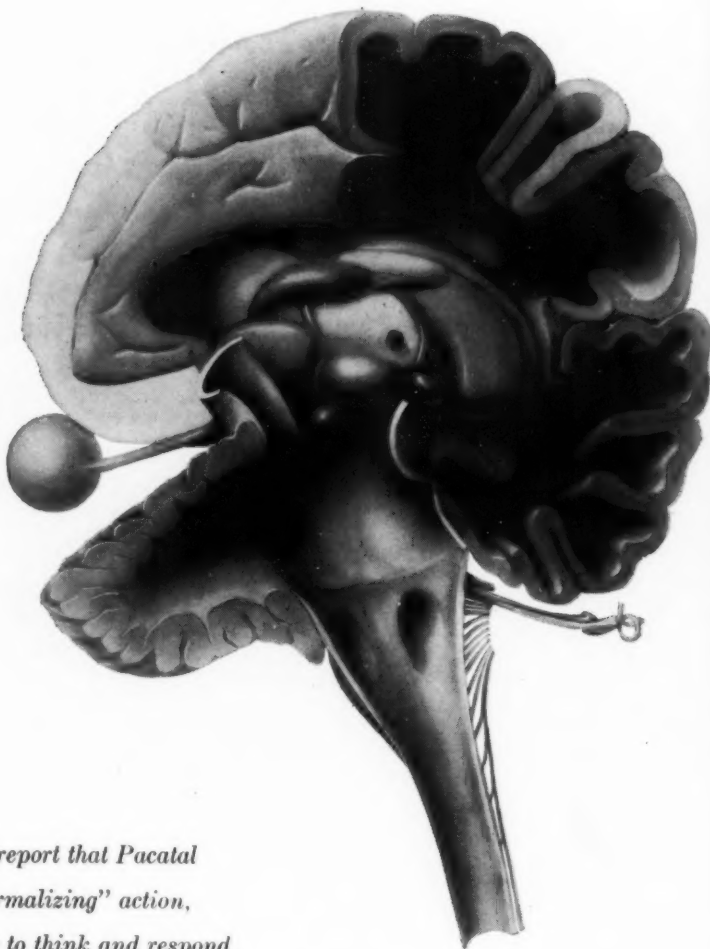
WARNER-CHILCOTT

100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

NEW

PACATAL[®]

(BRAND OF MEPAZINE)



The Twenty-Four Hour Care of the Patient

By HARRY C. SOLOMON, M.D., President, American Psychiatric Association
Superintendent, Massachusetts Mental Health Center, Boston

THE VISITOR to any large mental hospital who is uninitiated in the hospital care of the mentally ill patient is almost invariably deeply shocked and disturbed by the sights he sees. This is true not only of the layman but also of medical students and students of social work, social science, chaplaincy and others. To the hospital worker this reaction on the part of the visitor seems somewhat naive and ingenuous. What does this difference of attitude mean? Probably it arises from the sights being novel and unexpected to the one group and customary and habitual to the other.

What is it that members of the first group find so distressing? Among the causes of distress are the rather meager, unattractive physical surroundings, the inactivity and lassitude of the patients and, not least of all, the generally unkempt appearance of the patients. How has it happened that these conditions have come about? Certainly the same general conditions exist throughout the public mental hospitals of the United States, so one may assume that it is a social convention that has grown up over a period of years. Apparently no person in authority has been able to cope with these conditions. It may be concluded then that the full twenty-four hours of the patient's day have not been well planned or well managed.

It is probable that this was not always the case. As one reads accounts of hospitals early established in this country, the facts seem to have been quite different. The accounts of programs for patients written in the early part of the last century, such as those emanating from the McLean Hospital, Hartford Retreat, Bloomingdale Asylum and even state hospitals such as the Worcester State Hospital and the Boston State Hospital, depict something very different. At this early period meticulous consideration was given to the comfort and welfare of the patients. Facilities for work and play were quite adequate. The social amenities were given much consideration. A sympathetic and understanding attitude was inculcated, as far as possible, in all members of the staff. This attitude can be gleaned from the repeated statements of consideration of the dignity of man and from Horace Mann's definition of moral treatment as the law of love.

It must be borne in mind that these early institutions were small in size, at first 100 or less beds. As time went on the hospitals rapidly increased in size despite the efforts of the great men of the time. Many of the original founders of the American Psychiatric Association fought

valiantly but unsuccessfully to limit the size of the mental hospital to 250 beds. With the great increase in the size of the hospitals, it was not possible for the Superintendent to keep in close touch with the details of management on an individual and personal basis; nor were the defects resulting from this lack of the Superintendent's personal touch corrected by the development of highly skilled and able staff to assist him in supplying the many essential services.

The alarming cost to the taxpayer, resulting from larger hospitals, led to progressive, relative reduction in per capita budgets, with consequent deterioration of service. For instance, in 1840 the cost of hospital care in the general hospital such as the Massachusetts General Hospital of Boston and the state institution was at a ratio of two to one; that is the cost at the Massachusetts General Hospital was \$7.00 per week per patient, whereas that of the state hospital patient was \$3.50 per week. One hundred years later the differential was approximately ten to one, and in some instances greater than this.

The primary question is whether the level of care is an important determinant of the outcome of mental



HARRY C. SOLOMON, M.D.

illness. At the present time many hospital administrators and their personnel are once more optimistic about what can be accomplished by an improved physical and social environment. They have taken the viewpoint that poor conditions of care and treatment exist in their institutions which lead to deterioration rather than to improvement. Some believe fervently that when conditions are salutary the improvement and recovery rates are greatly enhanced, not only for the patients who are newly ill, but for those who have been ill for long periods.

Living Conditions Help or Hinder Readjustment

It would therefore appear timely for careful review and studies to be made regarding the importance of the various elements which go into hospital procedures and the conditions under which patients live. Three books have recently been published that attempt to offer the results of investigation into such problems. These are (1) *FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS*—by Greenblatt, York and Brown; (2) *THE MENTAL HOSPITAL: A STUDY OF INSTITUTIONAL PARTICIPATION IN PSYCHIATRIC ILLNESS AND TREATMENT*—by Stanton and Schwartz; and (3) *HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL*—by Belknap. These three volumes, as well as a number of shorter papers, present facts as seen by the authors and form the basis for additional studies aimed at improving both conditions of care and the more definitive treatment of the mentally ill. The first two books mentioned are collaborative efforts of the psychiatrist and social scientist. The third book is the result of studies by a sociologist. A fourth publication will soon be out consisting of papers given at a conference on *Socio-Environmental Aspects of Patient Treatment in Mental Hospitals*, in which the general subject of the therapeutic environment was discussed by a gathering of psychiatrists, social scientists and psychiatric social workers. Here then is evidence that attention, long overdue, is being focused on the problems related to the physical and environmental care of psychiatric patients.

I personally believe that every detail in the care of the mentally ill patient in a mental hospital is of importance in restoring his adjustment and adaptability to life outside of the hospital. This means that consideration must be given to the complete 24 hour a day living conditions of the incarcerated individual. Work and play, opportunities for initiative, the amenities of life, the aesthetics are all essential parts of the program. The question of how this all can be planned and on whom the responsibility should rest are important factors to be thought about.

Creating a Social Setting—a Great Challenge

It is a current statement that in most mental hospitals the patient is in longer and more intimate contact with the attendant than with any other person. It is generally conceded that there are not enough trained psychiatrists to serve all the functions of diagnosis and treatment as well as manipulation of the environment. Belknap suggests that the attendant should therefore be

a person of high educational background, good personality, devoted interest and considerable training in the art of caring for the patients. In addition to the psychiatrist and the attendant, the modern mental hospital has the assistance of nurses, social workers, clinical psychologists, occupational therapists, industrial therapists, recreationalists, chaplains and volunteers, not to mention the many others—engineers, carpenters, housekeepers, dietitians, sanitation officers, laundry workers, business and financial officers and others whose work only incidentally brings them into contact with patients, yet whose contribution to the general therapeutic climate of the institution is fundamental. However, the jurisdictional boundaries of these various individuals are rarely clearly defined practically or, for that matter, even theoretically and, as with the psychiatrist, the supply is in most instances far below the need.

The American Psychiatric Association has suggested minimal needs of the various workers in the hospital in direct contact with patients. I would take some exception to their figures as being far too low even as minimal standards. If one assumes that the hospitalized mental patient is to be prepared to live a life in the community and meanwhile to live a life in the hospital somewhat commensurable with that of the outside world, it means that the day's activities will begin around 7 in the morning and last until 10 or 11 o'clock at night. It is a tremendous challenge to create a social setting seven days a week for 15 or 16 hours. Mental illness usually carries with it a lack of capacity for easy socialization, constructive initiation of activities and a capacity for healthy enjoyment. The mental patient likewise is prone to be extremely sensitive, feeling deeply every slight and evidence of rejection. Inactivity often leads to harmful ruminations, discomfort to feelings of rejection. Lack of stimulation will likewise lead to isolation within oneself.

Sympathy Alone is Not Sufficient

The following is an endeavor to suggest the attitudes that one should try to encourage. The first is a hopeful and optimistic approach on the part of all who are in direct or indirect relationship with the patients. By this is meant not only a cheerful front but a genuine belief that the patient may be helped and an expectation of improvement. It appears that there is today good reason for having such an expectation. In our own local experience, more than 90 percent of the patients who enter the institution leave in a matter of months improved and able to take up some reasonable community life. A recognition of the capacities and potentials of the patient is necessary and an atmosphere should be created that makes the patient aware of this recognition. Sympathy alone is not sufficient. Evidence of understanding of the patient's potentials as well as his needs is a requirement. Stimulation of initiative with an opportunity to carry out healthful activities on his own should be provided.

To foster such an attitude in personnel is the great challenge. If this is to be achieved, every employee must feel his own importance and dignity, have his own opportunity for development of initiative and responsibility, feel content in his relations to his co-workers and receive recognition for his efforts. If personnel are

not to be coercive in their treatment of the patients, they should themselves be protected against hierarchial coercion. This, I believe, is the true basis for the concept of teamwork. Patients should acquire a sense of social solidarity amongst themselves by having the opportunity for work and play together. Work is an important activity in the life of most individuals and should be for our patients; it should not be arbitrarily assigned but rather based upon both the equipment and the capacity of the patient. Stenography, laboratory work and work that requires skills held by the patient should be made available. Educational opportunities are essentials both for staff and patients. A voice in the rules and regulations is a reasonable expectation of the patient. The Patient Government organization affords some opportunities in this direction.

The Patient's Problems of Daily Living

I believe it is fair to say that most of us in time become blinded or insensitive to the indignities that are so easily heaped upon our patients. How does a patient get a light for cigarettes if matches are withheld for safety reasons? How can a patient feel comfortable if he has no money at his disposal? How can a man be expected to keep up his self-respect if he has no opportunity to shave? How does a woman feel if her wedding ring is forbidden her? How can a patient feel comfortable if his glasses or dentures are removed? How can he maintain his dignity if his clothes are poor in quality and style, if his shoes do not fit or are dilapidated and never shined? The lack of personal possessions and of a place to keep the few that one may acquire are humiliating. Locked doors with rattling of keys must be distressing. The lack of easy communication or association with the opposite sex is hardly similar to the way of life outside the institution. These and a myriad of other details go into the problem of the daily living of the patient.

Who is to be aware of these details and who has the opportunity and authority to correct them? Those of us who live in daily contact with the problems develop many blind spots. Those of us who are burdened with what seem like major responsibilities are often unavailable for the consideration of the patients' everyday needs. If any great improvement in the hospital standard of living is to be accomplished, the problems must be carefully and repeatedly studied. The superintendent himself and all the people who work in the hospital need the help and advice of trained observers—perhaps anthropologists or sociologists—to re-sensitize them and alert them to the things which make it difficult for the patient to live as a human being with the rights of privacy, comfort and dignity. We are too often oblivious to the effects of the things we do daily. The trained observer can analyze the details and suggest, to those who make the policies of the hospital, improvements which might result from changes. But to make the changes and to make ourselves aware of the needs is the responsibility of every worker in every area who must make every effort to build a more congenial world for the patient. It is a continuous and ongoing responsibility. It is the duty of everyone of us—and a job that is never finished.

M. H. S. Salutes



AUSTIN M. DAVIES, Ph.B.

Some people always get called by their given names. Several thousand psychiatrists have called Austin Davies "Austin" for twenty-five years—and for lesser periods so have most of the staff members of the A.P.A. Austin is a personal friend of us all.

It never occurs to him that this informality threatens his dignity. He accepts it as the simple tribute it is—a tribute to his helpfulness, friendliness and loyalty to us all.

Austin does a lot of work with a minimum of fuss. He arranges the Annual Meetings; he is the Treasurer's right hand; he is the business manager of the American Journal of Psychiatry. He answers questions on insurance; on income tax; on hotel accommodations; on advertising policies and the thousand and one other problems which beset the A.P.A. offices.

At the 113th Annual Meeting of the A.P.A.—Austin's twenty-fifth anniversary—the members of the A.P.A. presented him with a fine silver bowl and an illuminated address. MENTAL HOSPITALS is proud to pay this more modest but just as deeply felt tribute to its good friend.

Conclusion of the Series on Mental Hospital Administration

HOSPITAL ADMINISTRATION AND THE MEDICAL SUPERINTENDENT

By DANIEL BLAIN, M.D.

Medical Director, American Psychiatric Association

THE *MENTAL HOSPITALS* series on hospital administration contains many allusions to the duties and responsibilities of the Superintendent. Myers and Smith have emphasized the personality of the hospital: "It has a set of motivations. It is as complex as the number of its employees. Its service depends on its emotional tone and atmosphere. . . . The orientation and personality of the superintendent, perhaps more than any other single individual, will influence this emotional climate." Ewalt says that the Superintendent and his chief aides must plan (and budget) for new developments, changes in function and treatment, expansion or curtailment of services, space requirements, personnel requirements, inducements and special programs. Braceland writes: "The quality of any training program depends upon the people who run it, their philosophy, training and ability and on the effectiveness of the psychiatric work of the institution that conducts it." Cromwell points out that good public relations is dependent both on internal hospital activities and efforts outside to change public opinion. Barton believes that the principal aspects of management are education, communication and integration. Dunlap and Applegate remind us that the Superintendent must start his day knowing that the feeding, housing and supplying of the patients and employees are satisfactory, and knowing that the business manager has a clear understanding of

This article concludes the Series on Mental Hospital Administration, which began in the March 1956 issue of *MENTAL HOSPITALS*. It comprised a total of 23 articles, including the above. Fourteen of these were based on the areas set forth by the A.P.A. Committee on Certification of Mental Hospital Administrators in their booklet of information for applicants; four were additional articles on training programs for various disciplines, and four dealt with the administration of psychiatric facilities and agencies other than the public mental hospital.

It is planned to gather the series into a reprint of approximately 64 pages, to be published during the summer. Price and availability of the reprint will be announced at a later date.

the needs of the various groups of patients. Zimmerman and Kusner have demonstrated how food services must be geared to special needs, and Davidson has discussed ten ways in which the Superintendent will be called upon to exercise legal responsibilities.

Unique Character of Psychiatric Patients

The nature of psychiatric patients makes the administrative job more complex in the mental hospital than in the great majority of general hospitals. Whereas the mission is the same—the diagnosis, treatment and rehabilitation of patients—the nature of mental disorders (See Section I of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, for the seven main categories) calls for full appreciation of the psychological, social and biological needs of human beings, exaggerated as they are by the disease process. In mental hospitals, the progress of patients is characterized by varying degrees of success. The acute stage of mental disorders lasts longer than the acute phase of most physical disorders, and social adjustment is in itself a more important goal. Such adjustment is not only one objective to work towards, but is, in itself, visible evidence of progress.

Thus, in addition to its psychiatric and general medical program, and the necessary physical care, the mental hospital must provide opportunities for activities related to community living, such as increasing self-sufficiency, social relationships, and, on occasion, vocational training so that the ex-patient may earn his living. Participation in these activities is very much a part of the total treatment program, and at the same time, a demonstration that progress has been made.

Social conditions within the hospital must combat the inherent tendency toward isolation which is common to most mental patients by reason of their illness and of the common social rejection by others. Thus efforts must be made to provide a special milieu within the institution, and constant contact with home and normal social life.

A psychiatric hospital, more than any other, must reflect the best known theories, hypotheses and proven facts relating to the demands of the human psyche when under the strain of mental disorder. It is an oft-proven

fact that mental disorders are especially influenced by the environment in which the patient finds himself. Stanton and Schwartz have presented a large amount of evidence to show how the interpersonal relationships between all groups of patients and personnel, strongly influenced by inter-staff relationships, will augment or retard patient improvement and offer further proof that ward and general hospital atmosphere are a potent force in patient progress.

Special Problems

Mental hospitals are characterized by a number of special problems, concerning which lengthy discussion is not needed here. Size is one factor; the hospital often resembles a small village or town, with much the same physical services. An inherited load of long-term, aging patients is another. There is usually a backlog of patients in the community seeking admission when conditions seem encouraging. Shortage of personnel in all disciplines, instability of public support (if the institution is tax supported), public ignorance, apathy, prejudice, suspicion and misunderstanding of the hospital's function and of its patients and their disorders complete the melancholy roll of special difficulties.

Other special qualities of psychiatric institutions which offer a challenge to the top echelon of hospital administration are the fluid status of psychiatric science today; new modes and places of application of psychiatric services, such as the trend toward more day services, ambulant and home services, administrative experimentation demanded by new theories of disease processes and the legal technicalities so often presented to the hospital.

Another order of needed skills relates to the responsibility for the administration of large amounts of money, large numbers of employees, and special management problems with patients. These difficulties have always made public institutions vulnerable to political spoils systems, to constant investigation and to the need for constant defense before the public.

Administration is a Science and an Art

The author likes to think of "administration" as a way to get things done, and the ability to get them done smoothly, an ability which many people possess inherently, but which can be improved by study and experience.

The function of hospital administration, stated simply, is to furnish the framework in which treatment processes can operate. This framework is made up of organization and direction at different levels of professional services to patients. It includes the creation of a milieu conducive to patient progress and staff satisfaction, and good supporting services such as feeding, housing, and supplying the physical needs of patients and staff. All these functions must be carried out in a manner harmonious with the psychological needs of the patients, so that the hospital as a whole becomes a treatment tool in itself.

Administration is recognized as a science in that (1) it encompasses a special body of knowledge; (2) has a body of literature devoted to it; (3) has a group of persons engaged in the application of its principles; and

(4) is expanding through research. The American Management Association and the Society for the Advancement of Management are national organizations devoted to this science.

Urwick, in his classic handbook, *THE ELEMENTS OF ADMINISTRATION*, suggests that the science of administration is composed of three major principles—**Investigation** (data collecting), **Forecasting** (study of trends), and **Planning**, these three working in harmony towards the *Objective*. Each principle is divided and subdivided.

The **Principle of Forecasting**, for instance, is based on *Appropriateness* (making sure that resources and organization are suitable for the undertaking), leading by the process of *Organization* to the effect, which is *Co-ordination*.

The **Principle of Planning** has as its basis *Order*, becomes a process with *Command*, and leads to its effect *Control*.

The **Principle of Command** is considered to be *Centralization*, its process *Appropriate Staffing* and its effect, *Esprit de Corps*. *Appropriate Staffing* again works on the principle of *Selection and Placement*, as a process offers *Rewards and Sanctions*, and hopefully results in *Initiative*. *Esprit de Corps* finds its principle in *Equity*, works through the process of *Discipline* and has as its effect *Stability*.

The three basic elements, **Investigation**, **Forecasting** and **Planning**, are directed towards the *Objective*, which must be clear, appropriate and reasonable, sometimes immediate, sometimes remote, sometimes both. Some of the objectives of the hospital are, of course, set by law. Others will properly be set by professional standards. Each level of organization will have its special objective, but each of these objectives will be contained within the overall objective of the whole institution. So since the objective of a mental hospital is to treat mental illness, the objective of each unit of the hospital must be to assist and not deter this overall objective.

Thus the food service, for instance, while primarily for the purpose of providing nourishment, must pay special attention to those aspects of food service to which a mental patient might be especially sensitive. The exercising of choice, the elimination of noise, glaring lights, bustle, confusion, and overloaded plates, and the provision of a full set of silver and glassware, all have their psychological aspects which must be accorded every possible recognition.

The writer believes that no administrator can function successfully at the top level without some degree of knowledge about the elements involved in the overall objective, and in the immediate objective of each unit of the institution. To this end the Superintendent must keep in close touch with each department.

Administration is also an art, inasmuch as it calls forth in each person certain abilities not yet clearly defined, the possession of which may permit him to direct a program successfully by sheer native ability, without formal training or previous recognizable experience. These abilities are labeled "common sense"—"intuition"—"mature judgment"—"leadership" and other phrases which need more study. It is held by some that

such ability cannot be achieved by formal training and that, lacking that certain spark, one cannot go far in administrative work. Others believe that training can produce in anybody the capacity to be a good administrator. There is no doubt that training will add to the capacity of the "natural born" leader.

"Administration" is Basic to All Human Activity

Administration, as the word is commonly used, is understood to refer to top responsibility for a large enterprise; the administrator, the head of an institution or program. In psychiatric circles, there is a feeling that administration is something apart from the professional life of the physician. Certainly it has received little attention during the formal training of doctors in the past.

If administration is the science and art of "getting things done," perhaps it is after all something more simple and more common than is ordinarily conceived. If this is true then it may be found to be needed in all walks of life and at every level, not only of the professional activity, but of all activity which takes place among people, and among all disciplines working in the hospital.

If this is true, "administration" may be approached with less suspicion and distrust. It is worthy of a higher status in the professional education of doctors, and can more easily be accepted as a necessary part of the physician's role. As it becomes a more and more important tool in the total operation of the hospital, it may, for purposes of study and elaboration, be treated as a separate and distinct entity. Acceptance of such a concept will make it easier for the doctor to see hospital administration as an extension of his role as therapist, because he will recognize that he is providing the means which enable psychiatric and somatic therapies to be given to a larger number of patients than he could treat personally. Hospital administration will then rightfully be conceived as an important tool in itself.

Each "His Own Administrator"

It is clear that the process of administration may be carried out on a small or a large scale. Its two main facets are responsibility and authority—necessary ingredients of all activities over which the individual has any control. On a large scale it will become an entirely separate function. But at each level of hospital operation, administration means the carrying out in an orderly fashion of the function of the unit, through intelligent and thoughtful organization and leadership. At each level some individual is in charge of this organization and direction. Direction should include an indirect stimulation in place of use of authority. The implications of being "in charge" include responsibility and authority.

Authority, which stands for force or power, derives from various sources. That of the superintendent stems from his appointment, from his legal position as a licensed physician, and from his job description, but it must also emanate from his internal strength, intelligence, character and integrity. When he delegates responsibility to the heads of the different operating units of the hospital, he permits them, by proxy, to exercise portions of the authority which are, in fact, invested in himself.

The author would like to suggest that "administration" has a personal quality, hoping this is not considered too broad a use of the word. The individual seldom recognizes that, in whatever capacity he works, he himself is the primary unit of administration. Even in his personal life he is an administrator! He has the responsibility to get himself started each morning, bathe and clothe himself, take nourishment, conform to his environment, and to be moderately successful in these minimum objectives. He must guide his own activities with some degree of direction and orderliness. In a democratic society, he will achieve authority commensurate with his responsibility, and ideally both authority and responsibility will be appropriate in degree.

Increase in personal responsibilities demands greater and greater authority or administrative power. The willingness to accept this is in one sense a demonstration of maturity. The cutting of the apron strings, the striking out for oneself, the taking of a job, the establishment of a family, when done in a responsible manner, are evidence of a willingness to accept more and more "personal administrative responsibility." To increase knowledge, earning power and the ability to get things done is to advance as one's own administrator. These skills, necessary in all people, are in essence the same skills which the top administrator needs. To advance by finding better, easier and cheaper ways (in money, time and manpower) of getting a job well done is worthy of man's best creative efforts. The physician will be fortunate if he gets part of his reward in this aspect of his work.

The perceptive individual will soon learn that one of the great factors in interpersonal relationships is to recognize the need of the other person also to be "his own administrator," to encourage and help him to achieve that independence, and to create a situation which will allow this growth. The mentally ill need special help in developing personal responsibility and assuming the authority to organize and direct their bodily mechanisms and individual activities. Much hospital therapy is planned specifically to restore such individual administrative processes and the necessary motivation to this end. The hospital employee, therefore, in recognizing his own needs for this type of independence will be better able to encourage and permit his patients to exercise choice, develop self-status, keep themselves neat and clean, and engage in self-government in groups once they can achieve it again as individuals.

Administration a Means to an End

Administration is not, however, an end in itself. It is the tool for achieving the main objectives of the individual or the organization. In the case of the mental hospital, these objectives are, by means of the effective use of therapies as they exist today, (a) to assist sick people to get well; (b) when that is not possible, to help them improve; and (c) to help them deal with a long term or permanent disability in such a way that some satisfactions at least may be salvaged. These special objectives, requiring so many participants, will influence not only all the administrative procedures of the hospital, but its entire administrative leadership.

The basic administrative unit of the psychiatric hos-

Chamberlin Psychosecurity Screens

PERMANENTLY AND SAFELY SOLVE PROBLEMS OF DETENTION

PREVENT ACCIDENTS AND ESCAPE

REDUCE LIABILITY HAZARDS

PROVIDE PATIENTS' PEACE OF MIND

EASY TO INSTALL ON ANY WINDOW

SERVE AS INSECT SCREEN

What Price
PEACE OF MIND?

WHERE
PROTECTION
AND DETENTION
ARE NEEDED

Patients rooms
Corridors
Solariums, day rooms
Toilet rooms

Disturbed wards
Alcoholic wards
Nurses' stations
Observation rooms

Examination rooms
Waiting rooms
Delivery rooms
Emergency rooms

Treatment rooms
Windows accessible
to prowlers

3 CHAMBERLIN SCREENS MEET THESE NEEDS

OVER 100,000 IN USE
CHAMBERLIN HAS
INSTALLED MORE
PSYCHOSECURITY
SCREENS THAN ALL OTHER
COMPANIES TOGETHER



(A) Detention Type



(B) Protection Type



(C) Safety Type

(A) DETENTION TYPE to withstand the fury of violent attack.

(B) PROTECTION TYPE for the less violent patient.

(C) SAFETY TYPE for mildly disturbed patients requiring protective custody.

SUPERIOR ADVANTAGES

- NO STEEL BARS—ordinary screen appearance implies no sense of restraint—presents no prison look.
- ALL STEEL FRAMES—shock-absorbing stainless steel mesh is suspended to the heavy steel frame by concealed springs.
- ECONOMICAL—installed inside window to reduce maintenance, glass breakage, serve as insect screens.
- EASY TO CLEAN—simple and easy to keep sanitary.
- NATION-WIDE SERVICE—assures professional factory attention and immediate expert service.
- HOSPITAL ADVISORY STAFF—write for guidance and full details on Chamberlin's service to hospitals, institutions and architects.

IN CASE OF FIRE—

EXCLUSIVE CHAMBERLIN LOCK
RELEASE ON OUTSIDE OF SCREEN
—READY FOR EMERGENCY RESCUE



In the Psychosecurity Screen field, Chamberlin leads in design, engineering, manufacturing and advisory know-how. You can depend upon the ethics and the service to be expected from a concern that's been in business 58 years.

Get the Facts on

CHAMBERLIN
CHAMBERLIN COMPANY OF AMERICA

Psychosecurity Screens
CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSIE STREET • DETROIT 32, MICHIGAN

CHAMBERLIN INSTITUTIONAL SERVICES also include Mineral Wool Insulation, Metal Weather Strips and Caulking, Metal Combination Windows and Doors, Metal Insect Screens, Aluminum and Fiber Glass Awnings.

pital is the ward where the patients actually live. The organization on this level is a microcosm of the total hospital organization, for the administration of the ward is a psychological, social and biological operation. Here is found the heart of milieu therapy, now recognized as being one of the most potent forces to assist specific therapies, and often, in the absence of such specifics, as the cornerstone of the therapeutic edifice.

The ward officers—the ward psychiatrist, chief nurse and often the “charge attendant”—administer these wards, and their individual successes are indices to the success or failure of the whole hospital. The ward workers are the contact point with the patient. This contact might be termed the bridge or perhaps the “synapse” between the patient and the hospital as a total therapeutic entity. The contact is most often made by the aide, less often by the nurse in her less numerous contacts and still more infrequently by the psychiatrist in his rarer patient contacts. But it is also furnished by everyone in the hospital—the elevator operators, the typists, the volunteers, the maintenance men—whenever they come into contact with patients.

It is the nurse and the psychiatrist, of course, with their greater experience and skill who must observe and direct the whole treatment process on the ward. They need the same administrative skills as those in the top echelons. It is they who apply these skills directly to the patients and to those who spend all their working hours with the patients. The progress of their patients will depend largely upon how these ward officers succeed administratively in helping the aides to do a good job, to carry out orders, to activate a well planned regime, and to help with the occupational and recreational therapy programs on the ward. Success too will be achieved to the extent to which these aides make good use of their time, are interested in the patients, and have learned by teaching and experience to understand their patients.

Good top administration and professional leadership will already have clearly defined the objectives, functions, responsibilities and authority of these ward officers (doctors and nurses), and hopefully will have furnished sufficient help to get the job done. It is the duty of the ward officers to exercise all their ingenuity to create and simplify orderly processes which distribute labor, make the best use of available skills and leave time and opportunity for all hands to develop constructive relationships with the patients. The ward officers who recognize the advantages of good ward administration will not begrudge the time necessary to discuss various aspects of this administration with all personnel, both in groups and individually.

They will also understand that communication with patients, between aides and nurses and doctors, and ward personnel with other hospital workers is an essential part of good ward administration. Non-verbal communication is often more important than verbal. We would hope that psychiatric workers, above all others, will understand that actions speak louder than words. These ward officers will accept paper work to the extent that it is needed. Reduction of paper work, without damage to communication, but rather to its improvement, is a goal eagerly to be sought. From ward personnel should come many of

the ideas for improved methods of handling patients, of establishing useful, accurate communication and for the improvement of all aspects of ward administration.

Directors of services and business managers, chiefs of departments and clinical directors have the same need for administrative skills, applied a little differently, and at a greater distance from the patient. These individuals must operate through more levels of people to influence the patients, and they will meet with greater difficulties and more potential obstruction. Hence they will need even more precise communication. Precise communication as a part of effective administration is becoming increasingly important as we move further away from the patient and as the organization becomes larger.

The Superintendent (An Admittedly Idealistic Concept)

The Superintendent himself is the key to a successful hospital operation. He can make the institution indifferent or outstanding. Failure of top leadership can permit breakdowns in communications, isolation of efforts, amazing deterioration of services, the formation of selfish power cliques, rapid turnover of staff and poor care and treatment of patients; undercurrents of discontent grow; opposition forces organize in retaliation. “Informal organization” may become a malignant thing and the superintendent finds himself and his hospital in serious trouble.

The good superintendent, however, does not himself attempt to play every instrument in the band. He is the first to recognize his need for the support of good top assistants who will be responsible for such activities as research and training, personnel, business and finance, maintenance and supply, discharge and follow-up; and of good clinical directors. He also recognizes the importance of the associated professions of psychology, nursing, social work, occupational therapy and rehabilitation workers, chaplains, and others. He knows the value of the volunteer program, the necessity of public relations and of public education to keep the community and the profession informed about hopeful advances, new techniques, need for adequate staffing, need for capital improvements and for necessary budgets. He will personally have to lead these efforts.

Because his job and his professional competence is for the one purpose of returning the patient to the community, he will bend every effort to inform himself and all members of his staff about community needs and community resources, in the areas from which his patients come, and to which, hopefully, they may return. Where no adequate resources exist, he will feel it is his duty to help develop them to facilitate patient discharge and follow-up.

The Commissioner of Mental Health at the state level (or his equivalent) has very similar responsibilities to those of the hospital superintendent, but on a wider scale. This administrator will have to be cognizant of the needs of all the citizens of the state and be acquainted with all the available resources. He will have to appreciate state-wide and national trends so that his state can develop a program in keeping with the best professional thinking. He will work toward the development of com-

mental services as a partner in the rehabilitation of the patient. He will help in the development of the non-psychiatric welfare services now being recognized as a potent preventive force. He will of necessity stand firm on his knowledge of what his patients need and make his requests only from that point of view.

The psychiatrist who is an acknowledged leader in his profession has a great advantage in a hospital or a state service position, for several reasons. His professional position makes him less vulnerable to pressures to compromise, to yield to selfish interests or to be afraid of being forced to resign. By virtue of the type of education and experience he has had, he will have a store of valuable knowledge, an inner confidence and a demonstrated usefulness on which he can rely. He is the fortunate custodian of the strength and independence which the medical profession and society accord him as one of its responsible members.

Being therefore personally, professionally, socially and economically secure, he can be independent of all things except his own professional and ethical standards. In moments of stress and discouragement, or after a long period of hardship or overwork, the weary superintendent or commissioner will do well to consider these sources of strength.

The personality of the successful superintendent is not stereotyped. Many different kinds are successful. Only a few women, for instance, known to the writer, have held these top positions, but they have succeeded admirably, and it is to be hoped that others will follow their lead. On occasion, the absence of hospital administrative experience has not been a serious factor.

It is obvious that the superintendent of a mental institution should be professionally qualified, and, partly for his own soul's sake, should take pains to maintain competence as a psychiatrist. He should work with patients enough to maintain his status and "feeling" as a physician. He might well retain one ward for his personal responsibility. He may do some research of interest to himself on a certain group of patients. He should be active in all the inservice and professional training programs, even though he is fortunate enough to have a Director of Training.

He must of course have the maturity and personal integrity that one expects of anyone in a responsible position. He must be able to delegate authority and responsibility, but at the same time to accept the ultimate responsibility for all that is done, even though he has invited his staff to assist in arriving at a decision. These qualities engender and strengthen mutual loyalty between superintendent and staff.

He must know something about the science as well as the art of administration, and should take formal courses in this science. He must appreciate the importance of business methods and techniques even though he must always have a competent business manager. He will have to make final decisions in professional differences of opinion. He must know what is going on in the institution so that he can understand and evaluate the needs of different departments and remedy these when necessary. This information can best be obtained by personal contact and visits. He must respect and be a part

of the "informal organization" by which people work together, yet never fail to recognize his position and that of others in the formal organization.

He must be sensitive to the needs of people, as must any good psychiatrist, but must paradoxically be possessed of an innate toughness! He must be resilient rather than brittle. Sometimes he will need the courage to act in the face of external opposition. (If opposition within his own organization arises too often, he may suspect administrative failure somewhere along the line!)

He must be a hard worker, and unafraid of irregular hours, but he will insist that much of the detail be done by others. Successful recruitment and good staff organization will occupy an important part of his time. He will be available at all times to guide major policy decisions and to fight for the big things—public support, appropriations, research and training grants, and staff morale. He will need time to keep up with scientific and administrative advances and also keep a sensitive ear to the needs of his patients—and of his personnel.

He must be a true citizen of his community, bearing the general responsibilities of citizenship along with everyone else; he will have to switch from a professional to a general role for some part of his time. Yet he must never become politically partisan; his only loyalty must be to the needs of his patients.

He must be economically wise, politically prudent and have a keen sense of timing. He must know when patience is called for and when righteous indignation is appropriate and when a principle must be made the focus of a fight. He must be willing to speak in public and feel an obligation to do so. Even though he has a good public relations program with a director in his hospital, he will also recognize that much must be done by him personally, as the best informed person and the highest authority. He must accept being placed in the more or less continuous role of the father figure.

Personal characteristics which will help him include strong motivation, with a modicum of personal ambition; a crusading spirit; perhaps a degree of obsessive compulsiveness; good judgment; understanding of people and things; imagination and venturesomeness; a sense of timeliness, of the appropriate; ability and willingness to be patient; ability and courage to be impatient at the right time, to fight for a cause, and stake all on a single issue.

There are many compensations, though some are illusive. Certainly personal ambition is served. The high professional status, prominence and authority given to the small number who qualify, the opportunity to play an important part in progress, to help improve services for many more people than can be done on an individual basis—all are worthy aims for the professional person. It would appear at this time that improved training in administration and further advances in the science of hospital administration, with special reference to mental patients will materially enhance the efforts of the Superintendent. At the same time successful efforts of the professional and public leaders to overcome some of the obstacles should play an even more auspicious part in making the job of mental hospital administration more attractive.

Typical case:
"unmanageable"
schizophrenic
patient is hostile,
untidy and
inaccessible
to therapy.



the "before-and-after" picture in mental
wards continues to improve, case after
case, with **Serpasil**[®] (reserpine CIBA)

With Serpasil,
patient becomes
calm, cooperative,
amenable to interview . . .
as have thousands
in this new age
of hope for
the psychotic.



SUPPLIED:

Parenteral Solution:

Ampuls, 2 ml., 2.5 mg.

Serpasil per ml.

Multiple-dose Vials, 10 ml.,

2.5 mg. Serpasil per ml.

Tablets, 4 mg. (scored), 2 mg.

(scored), 1 mg. (scored),

0.25 mg. (scored) and 0.1 mg.

Elixirs, 1 mg. and 0.2 mg.

Serpasil per 4-ml. teaspoon.

C I B A
SUMMIT, N. J.

8/550000

CANADIAN HOSPITAL AND GENERAL HOSPITAL UNIT ARE 1957 ACHIEVEMENT AWARD WINNERS

Honorable Mention Certificates Awarded to State Hospitals in Washington and Indiana

Two Awards and two Honorable Mention Certificates are to be presented at the Ninth Mental Hospital Institute in Cleveland, Ohio, next September 30th. The four winners were announced at the opening ceremonies of the 113th Annual Meeting of the Association.

An Award of a silver plaque goes to the **Saskatchewan Hospital**, Weyburn, Canada. Dr. Humphry Osmond, Superintendent. To reorganize a 2000-bed public hospital, 110% overcrowded and with every ward a "back ward," was the task which confronted a new administration three or four years ago. The imaginative and novel use of a social scientist to help formulate and interpret the theoretical basis of the reorganization resulted in a totally different hospital milieu. The goals established were professional and therapeutically realistic and the policy of the hospital and the hospital budget were designed to meet these goals. Few new buildings were erected, but a great deal of furniture, equipment and clothing were replaced. Since staff morale was considered a prime factor, professional responsibility was made more direct and goals clearly defined. Restraint and seclusion are greatly reduced; formerly bedridden patients have become ambulatory; staff turnover has decreased greatly. The administration stresses the need for constant vigilance, good staff morale and continued public interest to prevent a return to the former conditions.

Another silver plaque Award goes to the **Psychiatric Department of the Receiving Hospital, Detroit, Michigan**, under the direction of Dr. R. R. Piper, Medical Superintendent. By integrating, coordinating, serving and utilizing the community's resources, the psychiatric department of this city general hospital is now able to fulfill its proper function—that of receiving hospital for short-term emergency

cases. No increase in personnel or appropriations was involved. The reestablishment of the outpatient department, the maintenance of close liaison with the probate court and other referral agencies, and consultation service to all public agencies and to other departments in the hospital have resulted in more satisfactory disposition of patients and eliminated the former overcrowding. A research and teaching program has been established in close relationship with the Wayne University Medical School. Recently, by amendment to the hospital Constitution, the department of psychiatry has been accorded major service status for the first time.

Northern State Hospital, Sedro-Woolley, Washington, Dr. Charles H. Jones, Superintendent, will receive an Honorable Mention Certificate. The physician recruitment program at this understaffed hospital was based on the belief that many younger psychiatrists were only too anxious to take part in new programs and to expand professionally according to their own particular interests. Accordingly, physicians visiting the hospital were shown the major deficiencies and handicaps and the possibilities of administrative changes were realistically discussed. As a result, the professional staff now numbers some 15 full time physicians and 9 consultants. There has been a significant decrease in the patient population, in spite of a steady admission rate. Thus the amount available as daily per capita has been progressively increased. This indirect increment has been used to improve the food service, buy new professional equipment, and to redecorate patient areas, adding immeasurably to patient comfort and to the morale of all who live or work in the hospital.

The other Honorable Mention will go to the **Madison State Hospital, Indiana**, Dr. Ott B. McAtee, Superintendent. A comprehensive effort on

all fronts to improve a very bad situation has achieved remarkable success in a short time. In 1952, there were only 365 employees, and the hospital was 45% overcrowded. There were no medical consultants, no pharmacy service, no planned X-ray service, no recreation or rehabilitation program. A vast backlog of patients had never had their histories taken or received any physical examination.

Today there are nine fulltime physicians, and close relationships with the general hospital and the University Medical Center have helped improve medical and surgical care. A fully developed social service program and an affiliate nurse program are in full operation. Medical records were modernized with the employment of a registered medical record librarian; a hospital-trained business administrator runs the accounting and the office work, a trained dietitian directs the food service, and the activities program is on a full-time basis. A full-time chaplain is on the staff, and a full-time director of volunteers runs an extensive volunteer program. The Fire and Safety Program has also been modernized.

Jay L. Hoffman, M.D.

With the death of Dr. Jay L. Hoffman, First Assistant Physician at St. Elizabeths Hospital, Washington, D. C., Mental Hospital Service has lost a good friend and strong supporter. Dr. Hoffman's most recent undertaking with the A.P.A. staff was as a member of the Planning Committee of the Conference on Volunteer Services to Psychiatric Patients. His prime responsibility at St. Elizabeths was to direct the program of education, research and therapy.

How the Mental Hospital Budget Looks to the Legislator

By J. R. HALL, JR., State Senator, Oklahoma State Senate

LEGISLATIVE INTEREST in the mental hospital budgets of the states has increased in recent years. This is due, in part, to improved methods of presenting the budget, more adequate reporting in the local newspapers and thirdly, to impetus from the Federal government. To be sure, the problem of balance between too much and too little financial data is ever present and continuing. Consequently, current legislative interest centers on items and details as well as on broad generalizations and rationalizations based on theories, premises, panaceas, conjectures, dreams and realities. "What is" and "what ought to be" are competitors for attention and analysis.

Reactions to the Budget

The budgets of the mental hospitals in the states are blueprints for annual or biennial fiscal periods. In most instances, therefore, they are a part of the consolidated budget of the executive type for the whole mental health program of the state. But the expansion of services and the constant addition of new programs leave the legislators in a dilemma. They are torn between the wish, on the one hand, to keep taxes down, and the necessity, on the other hand, of providing adequate funds for a constantly increasing number of essential mental health services. In the face of competing demands from other state programs, mounting costs for all services and the persistent public demand for economy, the individual legislator is understandably perplexed. He continuously finds himself in the turbulent throes of mental and emotional struggles to achieve the fictitious "balanced budget." His problem is

further aggravated by the fact that he receives conflicting demands from different sources. Intelligent judgment and action on budgetary matters, therefore, requires serious study and analysis.

Faced with this task, legislators seek supporting data to be sure that something is not being "put over" on them. Yet in many instances they are unable to interpret the material when it is presented because of the occupational terminology and the statistical approach. Consequently they dare not assume the responsibility for making large increases or large reductions in the budget requests. This is true, session after session, and the legislators vote—reluctantly in many cases—to approve all or most of the items submitted to them in the total state executive budget.

The result is that the growth and development of mental health programs rest for the most part on state executives. If the chief executive—the Governor—is capable and receptive to the mental health program, all is well. If he is not, the resultant competition for funds from roads and highways, education, public welfare and related activities is astounding. Often funds are provided for these, while mental health programs receive a minimum, with the promise of a larger take from the public till next time.

The legislators may be fearful in yet another way. Suspicious of the executive, they may look for a "bogeyman" in the appropriation requests. Yet scrutinizing requests line by line and item by item leaves many legislators bewildered, sometimes understandably so.

Supporting data for the budget, therefore, are urgently required to

educate the legislators. These, based on Oklahoma experience, are utilized best when issued as supplements; under this plan only items of interest to each legislator get his individual scrutiny. Comparison with what sister states are doing is often very helpful. Most legislators have an inherent desire to keep up with the Joneses.

Needed—A Crusading Legislator

Perhaps the most valuable means of presenting the supporting data, however, is through a well-informed "crusader" type legislator in each house of the legislature, who can work wonders. This gives you a friend on the inside, a member of the club, and will serve to minimize the elements of resentment which legislators sometimes direct toward an outsider who seeks to inform them. This legislator is in a position to continually support the mental health cause by frequent references to specific problems on the floor of the legislative body, in committees and in the "off limits" hotel room in the evenings. Of course the problem of the composite whole remains. Here the mental health finance officers must bridge the gap by means of adequate, well-presented well-considered budget requests.

Many legislators entertain the notion that superintendents and others charged with directing mental health programs are inclined to "do our best with what they give us." If this were true, it would be unfortunate because there rests on the professional shoulders of the superintendent or commissioner the primary responsibility to see that the story of his institution or program is presented to the legislature in its best light—and

yet also to reveal the inadequacies. On the whole, individual legislators will not resent this type of presentation, and it is certainly not beneath the dignity of a professional man to present it personally to his legislature. A trip to the legislative halls will go far to dispel any notion he may have that legislators are "rigged out in silver horns and long forked tails". He will find that they are men who, like himself, are anxious to do a good job and prepared and eager to understand the needs of his program.

Such a presentation by a superintendent or commissioner can be effectively supplemented by the use of well-informed members of community groups and other organizations. These citizens are always interested, and because they are voters are in a position to talk with individual legislators in their home districts and to present the mental health program in a way that will obtain maximum results.

Justifications of Requests

Personnel administration in mental hospitals is difficult. This is especially true for the lower echelons where the base pay is low. Consequently, the employee turnover is high. Difficulty is also encountered in recruiting and retaining experts in all fields.

Justification for personnel appropriations, therefore, should be based on program performance. This may consist in part of comparison of an immediate biennium with the previous biennium. Limited nose-counting and salary comparisons, however, must be supplemented by occasional job analyses and position classifications if the legislators are to view the requests as the reflection of jobs which must be done, rather than as meaningless numbers. It is much easier to cut down 150 aides to 100 aides than it is to decide that the wards at night must remain unsupervised!

Increases in the payroll figures, for practical purposes, are geared to the cost of living indexes and normal step-increases. Institutional standards may occasionally be employed as guides.

To grant an increase in the number of people on the payroll, the legislators must be sold on the proposition that the mental hospitals are being operated as efficiently as possible, and that efforts are being made to reduce the patient census. In addition, data

showing the comparison with the American Psychiatric Association minimum standards can be useful.

Whatever justification is presented will depend upon the matter being considered. Experience shows, however, that only limited statistics, reduced to the simplest terms, should be used. Simple graphs showing per patient per day expenditure and recovery rate are very useful and require very little reading time. These can be augmented with information on what could be done with more money.

Although clinical programs are the heart of mental hospital work, the data relating to their operation need not be too detailed. The relation of the clinical program to admission and population statistics is sufficient for general appropriation data. This may or may not be true in all states—it is true in Oklahoma. Case histories or summatory appraisals, almost without exception, are too unwieldy for legislative perusal and digestion.

Members of state legislatures are very interested, however, in the general service functions of mental hospitals. The hospital standard of living is easier for them to grasp than are the subtleties of psychiatric treatment. Unless, however, unusual reasons are presented for additional appropriations for this purpose, the answer is likely to be no. The service functions appear to be adequate as presented in information and publicity brochures. Legislators often feel they are the recipients of a "snow job" if more money is requested. Here again your crusader friend and citizens who have actually visited the hospital can do more in personal conversation to present the true picture than a thousand word formal presentation or justification attached to the budget request. Candid photographs of conditions which should be remedied can also be useful.

In the matter of requests for research funds, the guide here appears to be a matter of feasibility and need. For example, research in geriatrics is timely for Oklahoma at this time in order to determine the relation, if any, between mental illness and old age—a problem much in the public mind these days. Once again simplicity and brevity are needed in the justification. Page after page of tech-

nical information is lost on the average legislator who represents the majority in any legislature.

Being able to show results, even on a modest scale, is the best basis for requests for additional funds for research on the state level. Federal hand-outs, matching and otherwise, are apt to be examined with suspicion. Furthermore, spectacular research leaves the average legislator cold.

Deterrents to Appropriations

Ideally a budget for mental health programs will encompass at least three objectives: first, a financial plan on the basis of which the desired program may be accomplished; second, the means of securing funds from the state legislature; and third, the means for the control of financial transactions. These elements are found in varying degrees each biennium.

On the basis of the records of previous years, supplemented by temperate estimates of anticipated needs in the coming period, the budget for the ensuing year or biennium is made. Experience shows that requests should be moderate, but sufficiently high to permit bartering and trading to show legislative independence and to assure legislators that they are effecting economies through reductions.

Limits to budget requests which can be met are related to available funds, the program desired, the public relations program of the mental health department and the prevailing political climate. For example, an ineffectual public relations program may actually cause a reduction in appropriations by referring to a "do-nothing" legislature, or one having no concern for the "snake-pits" or "jungles" for the mentally ill. Discretion is the better part of valor—legislators have feelings too! This is not to say that members would be coddled or flattered. This would rightly be resented.

Finally, the integrated executive budget, presenting the total need of the entire state mental health program, including mental hospitals, schools for the mentally deficient, clinics and all other activities, appears to be the most desirable for legislative consumption. Needs and justifications are more meaningful in this total context. Per capita costs and institutional resources may be profitably presented graphically.

Announcing a unique new rauwolfia derivative...

First report on one of the
most encouraging advances
in psychopharmacology
since the introduction
of rauwolfia:

a tranquilizing-
antihypertensive agent
which combines the potency
of the rauwolfias with
significantly fewer and
milder side effects.

In mid-1955, Abbott Laboratories released for clinical trial a new alkaloid of *Rauwolfia canescens*. This new alkaloid, later named Harmony, received special attention because of the high potency and low toxicity it exhibited in pharmacological testing.

Since that time, Harmony has been tried in conditions ranging from mild anxiety to major mental illnesses and in hypertension. Every characteristic of the drug was studied . . . evaluated . . . compared. And from the reports, one fact stands out:

- In more than two years of clinical evaluation, Harmony has exhibited significantly fewer and milder side effects in comparative studies with reserpine. This, while demonstrating effectiveness comparable to the most potent forms of rauwolfia.

- Most significant: Harmony causes less mental and physical depression. *And there are very few reports of the lethargy seen with many other rauwolfia preparations.*

This is not to suggest, of course, that side effects will not occur with Harmony—as with any potent therapeutic agent. But the mildness of side effects, in the few instances in which they have been reported, suggests Harmony as a drug of choice in conditions ranging from mild anxiety to major mental illness and in hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less parasympathetic effect with Harmony in animals might also be true in man. In chronic toxicity studies with Harmony this was manifested by less diarrhea, “bloody tears” and ptosis in rats than was observed with the same dosage level of reserpine. Dogs also exhibited milder side effects—in particular, diarrhea. No organ toxicity or hematological change occurred over a wide dosage range.

Harmony as a tranquilizer

While Harmony's safety is most impressive, clinical investigators have reported other notable characteristics for this wide-range tranquilizer. For instance, following an eight-month study of chronic,

Harmonyl*

(Deserpidine, Abbott)

hospitalized mental patients, Ferguson¹ reported:

- Harmonyl benefited at least 15% more overactive patients than oral reserpine.
- Harmonyl was more potent in controlling aggression, requiring only one-half to two-thirds the dosage of reserpine.
- A number of patients experiencing side reactions during treatment with reserpine were completely relieved when changed to Harmonyl.

Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Harmonyl in hypertension

Hypertension studies show that the average reduction in blood pressure obtained with Harmonyl compares closely to that obtained with reserpine. The tranquilizing effect of the two drugs also appeared similar, except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Dosages In mild anxiety, as little as 0.1 mg. of Harmonyl a day may be effective. In institutionalized psychiatric patients, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25 mg. Harmonyl tablet three or four times a day. After about ten days (or sooner, depending upon response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.

Precautions, Contraindications As with other forms of rauwolfia, Harmonyl must be used cautiously in peptic ulcer and epilepsy and in patients about to undergo surgery or electroshock treatment. Despite the infrequency of reports involving depression, patients with a history of depressive episodes should be watched carefully.

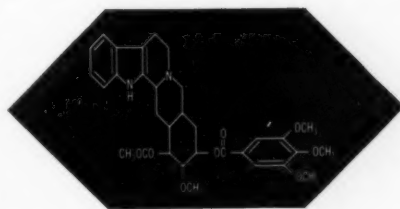
Professional literature is available upon request.

Supplied: Harmonyl is supplied in 0.1-mg., 0.25-mg. and 1-mg. tablets.

Abbott

Reference: 1. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, *Journal Lancet*, 76:389, December, 1956.*

*Trademark



Comprehensive Insurance Coverage for Hospitals

By LAWRENCE E. KEFER, Vice-President

Merrill Agency Inc., New York*

AN ESTIMATED 7000 American hospitals, and their highly competent and efficient personnel minister to the needs of some 24,000,000 inpatients and over 65,000,000 outpatients annually—a monumental public service. Monumental, too, is the investment in the facilities that make possible the efficiency with which a modern hospital functions. The monetary value of these facilities has never been authoritatively estimated; even if it were the estimate would be invalid within six months because of the pressing need for expansion and modernization, and the inflated cost of new and replaced real and personal properties. Whether the hospital is community supported, philanthropically endowed or a proprietorship for profit, the original need and the future aspirations of some individual or group are committed to the continued existence and operation of the physical facility.

It is around these—the physical properties and the humans who use them and keep them functioning around the clock—that this is written. It is an earnest effort to spotlight the salient hazards to which any such public institution is generally exposed. This paper is definitely not, however, to be construed as a “do-it-yourself” manual on how to fully recognize or properly insure any particular situation; this can be done only after a complete survey of each and every individual institution and only by a competent, highly experienced broker,

* *Underwriters for the Malpractice Policy available to members of the A.P.A.*

agent or advisor of your own choice and responsible to you.

When property of any sort has already been created, exposure to its loss is inevitable. One does not genuinely have an option whether to insure or not. The choice is, more realistically, whether to self-insure or, for a fixed consideration, turn the risk over to a professional insurer.

In certain areas, however, especially where the interests of others are concerned, there is literally no choice allowed. In the field of social insurance, for example, governmental bodies have imposed regulations that guarantee reimbursement. Workmen's compensation benefits, disability benefits, unemployment insurance, and old age insurance must all be guaranteed to the beneficiaries by regular contributions from the employer and into a formal authorized insurance fund—public or private. Mortgagees, whose funds often make the purchase of physical properties possible, demand adequate insurance against physical loss as a condition precedent to the loan. From here on—after those who can have secured firm and adequate protection—the choice as to whether to self-insure or to insure all the risk that is solely yours, must be carefully evaluated and periodically reviewed.

It would be helpful to recognize the fact that loss can be roughly divided into (a) actual physical loss and damage to property, (b) consequential loss, (c) loss arising out of actual or alleged injuries to members of the public or their property, (d) loss of prestige or good will which, although

unmeasurable, is corollary to the others.

There is no such thing as a fire-proof building. Fire-resistive structures, at best, can be expected to confine and minimize damage but, under a given set of circumstances, loss can be substantial both to building and contents. Basically, fire insurance policies are confined to insuring against damage by fire and lightning. Optionally, and at nominal additional cost, modern protection is extended to cover a large variety of other losses which, indeed, occur more frequently and occasionally cause more damage than would a fire. Under the terms of the so-called “extended coverage endorsement”, insurance is afforded against the named perils of windstorm and hail, explosion, riot and civil commotion, aircraft and vehicle damage, and smoke damage. This combined coverage may be purchased with, or without, a \$50.00 deductible provision and generally where sizable values are insured, the premium saving in the deductible form is advantageous.

Advantages of Term Policies

The saving to be derived by writing fire and allied coverage for terms of three or five years, where possible, is considerable. Three-year policies are written for two and one half times an annual premium and five year policies for but four annual premiums. Furthermore, most insurers are willing to permit installment payment of the three or five year contracts, and by the terms of the agreement the initial payment amounts to little more than

a single annual premium. The monetary saving, although considerable, may be the least of the advantages since, by contract, and in the absence of any increase in hazard, the prevailing rate at the inception of the contract is guaranteed against increase for the term of the policy; but the right to a lower promulgated rate during its term is retained. Additionally, circumstances change and companies have been forced, by legislation or experience, to amend the terms of their policies—some restrictive, some broadened. Possession of a term policy guarantees, at least, the initial protection for that term of years and, in most jurisdictions, the policy will automatically extend itself to include any broadened coverage that may be written into the policies during their term, and for which there is no additional premium chargeable.

Need for Revisions to Cover Increased Values and Costs

Term policies, however, cannot be placed in a safe deposit box and forgotten. Values may enhance appreciably by the acquisition of additional equipment or extensions to structures or by inflated costs of labor and material. Unless the amount of insurance is kept in proportion to values as they increase, a policy holder is apt to become a substantial co-insurer in the event of either a partial or total loss. New coverages are made available for a premium and your insurance advisor should be relied upon to bring them to your attention during the term of the policy. Should a decision be made to purchase them, they can be added for a pro rata additional premium. Since large values are involved, more than one company may be called upon to insure a given risk and, in the event of loss, all contribute in the proportion that the policy of each bears to the whole valid insurance. For full recovery, obviously, the written and printed conditions of each contributing policy should be identical, and a reliable insurance advisor will see that they are.

"All Risk" Policies for Equipment

Fire insurance rates, more than those for any other form of insurance, are largely within the control of the insured. Basically predicated on the construction of the building and its

proximity to fire protection, fire rates are subject to wide variance. Relatively small capital investments in improved physical conditions, improved housekeeping and "first aid" fire protection at the premises can pay handsome dividends in reduced rates over ensuing years and the initial outlay quickly recovered. Your insurance advisor or your company's fire engineers are equipped to make constructive suggestions.

Attention might profitably be given to the possibility that some of the equipment forming part of the contents may be insured under an "All Risk" form of policy rather than against specific perils. Scientific instruments, radium, and mobile devices and equipment, especially, can be better insured under a policy which is essentially "All Risk", with few exceptions and covers the insured objects wherever located or while in transit. The full range of equipment that can be insured in this manner varies with each institution but it can be itemized for you by an insurer familiar with the subject. If special equipment is so insured, its value may be deducted from the contents fire insurance policy.

Separate Insurance Needed for Boiler Explosion

Explosion, under the extended coverage endorsement, does not include the explosion of steam boilers and appurtenances, nor rotating parts of machinery if owned, leased by, or under the control of the insured. Separate insurance for steam boilers and pressure vessels is "preventive medicine". A major portion of premiums paid for this coverage is assigned to the cost of regular, periodic inspection service. Possession of a policy is a dual guarantee of prevention of loss, insofar as possible, and reimbursement and indemnity in the unfortunate event that preventive measures fail or are inadequate. The extreme importance of this coverage to any institution in which large numbers of people are exposed and the absolute necessity of providing continuous uninterrupted service, is apparent. Aside from the fact that such a policy provides indemnity for loss to the boiler, damage to other property of the insured and damage to property of others, an important fea-

ture is a so-called "expediting" limit* which can be expended for any service which will hasten repairs or replace parts necessary toward putting the plant back into commission at the earliest possible moment. Together with an insurance company's inherent knowledge of the availability of parts, this should guarantee a minimum layup period. Although virtually any type of pressure vessel can be insured, coverage against damage to any other object is optional. Objects are specifically scheduled and only those listed are charged for.

Power plants, generators, dynamos, motors etc. can create similar damage and cause cessation of activities. Available coverage follows, generally, the form and provisions of the boiler policy and, although prudent to insure the more costly, difficult-to-replace objects most essential to operation of the building, generally speaking no attempt should be made to cover smaller motors and attachments that are readily available at moderate cost and can cause little damage or inconvenience.

Crime coverage is obtainable in many and various ways. Specific policies bearing strict definitions of the limited circumstances under which they cover are available at a very nominal cost and, as a prerequisite to recovery, there must be some form of violence or threat of violence present. As the writer sees it, these are of little use to a public institution such as a hospital.

Value of a Single Loss Policy

The most foolproof of all crime protection is a single policy which affords protection in the event of dishonesty, mysterious unexplainable disappearance or destruction. The premium for this coverage will be found to be little more than would that for the same amount of insurance in specific policies. It covers inside

* The sum of \$1,000 is allowed without dispute to expedite delivery of parts, overtime labor, etc. required to put the boiler back into operation with the minimum of delay. Under another type of coverage, known as the "repair and replacement policy", an irreparable boiler will be replaced without taking into consideration depreciation of the old boiler.

and outside the premises, optionally, and against virtually "all risk". As an extreme example, if currency should be accidentally swept into the refuse and incinerated, blown to the four winds or just disappear, this is the coverage one would wish to have.

The dishonesty section may be arranged so that the amount insured is applicable to *each* employee involved in any one loss, or applicable to the whole loss regardless of how many employees are involved. Although the first is the more expensive it is, obviously, the more advantageous since the total amount recoverable is the amount of the bond times the number of implicated employees, except that it will not be responsible for any one for more than its face amount.

Although the dishonesty portion is applicable to loss of money, securities and merchandise, the balance is confined to money and securities. Should it be desirable to cover drugs, medicine, supplies and other property against crime committed by other than employees, it can be accomplished by a burglary and theft extension to this policy or, if specific insurances are carried, by a separate burglary and theft policy. The reference to theft is particularly stressed. The basic burglary policy, without this extension, specifically refers to the fact that there must be visible evidence of forcible entrance on the exterior of the premises and while they are closed to business. If a specific storage facility can be provided and if it can be designated and defined as "the premises", burglary insurance alone might be sufficient. Since most institutions are in 24 hour operation, coverage for theft is much more realistic. In neither event, however, is unexplained inventory shortage insured.

"Consequential Loss" can be Insured

Although the foregoing treats but by no means exhausts the clearly visible source of loss that makes headlines when it occurs, there is a second, and more insidious type, the potentialities of which are frequently unforeseen. Although often far in excess of the physical damage loss which caused it, it is seldom publicized and the magnitude rarely becomes public knowledge. These are consequential losses.

There is a nice and extremely im-

portant distinction. All the foregoing policies, somewhere in their verbiage, state that they shall cover "*direct* physical loss and/or damage to the property insured".

A fine hotel suffered trifling fire damage to the lobby. This was rapidly adjusted and the loss paid. Access to the lobby was impossible for hours; the dining room could not be reached and several days were consumed in repairing and refurbishing the lobby. The fire damage was "direct loss", and minor. The loss of patronage was "consequential"—and very sizable. The anticipated profit was, however, not the final measure of loss for, despite the cessation of business, expenses continued unabated. The reference to a hotel is illustrative only and it is not difficult to imagine the tremendous loss that could be incurred by any type of organization, dependent upon the continued use of its facilities, should it be materially damaged.

This risk can be insured and, particularly for a proprietary institution, might be considered an essential part of an insurance program. The need for this coverage by philanthropic or community hospitals is not to be minimized, for if no profit is made—indeed, if running at a loss—fixed expenses must continue and such a policy will cover them to the same extent that they would have been covered had normal operations continued uninterrupted. In fact, this coverage does for an insured that which the business itself would have done had no fire or other insured happening occurred.

Other Types of Contingent Loss

A somewhat different type of so-called "consequential" loss is created if a quantity of food or medicine or drugs, that must be kept under refrigeration, is spoiled or rendered unfit for consumption because of a happening that did not directly cause the spoilage but did attack the source of refrigeration. Direct loss may have been confined, for example, to the source of power but the rising temperature is but a consequence of the primary cause of loss and, hence, uninsured unless specifically assumed by the policy. The means by which each institution secures power for the maintenance of refrigeration governs

the manner of properly insuring this risk.

Communities are continually imposing more stringent regulations over building requirements with particular attention to those in which large numbers of people gather—and particularly hospitals. New rules governing the construction of institutional type buildings are promulgated and usually forbid repair or reconstruction of certain types of buildings if damaged beyond a percentage which varies with the community regulations. Because of their age and the era in which they were built, many hospitals fall into this category. There is a double peril for the insured in this situation, in that the physical damage policy covering the loss is generally obliged to pay only for the cost to repair or replace it with a structure of like kind and with due consideration to depreciation. A very fine spacious old building may be performing every function that a modern one could, and would possibly be adequate for many years to come. If, however, it suffered a sufficient partial loss to make the building code operative, another form of contingent loss is established and the possibility should be recognized. On one hand, the insuring company will only pay the amount necessary to repair the structure to place it in the same condition that it was before the happening. On the other, the law will not permit its reconstruction. The result is that the undamaged portion must be demolished at considerable cost, and a new building erected in accordance with the currently applicable building code which will, inevitably, call for modern up-to-date construction. It is not possible in this limited space to go into specific methods of covering this possibility. These are subject to State regulation and differ so widely that no general statement would be at all inclusive. Such a problem should be thoroughly discussed with your insurance advisor, who should be in a position to develop the proper method of covering this hazard.

Vulnerability to Third Party Suit

It is in the area of third party liability insurance, where one can least control destiny, that pitfalls abound and the most careful scrutiny must be given to the circumstances of

each risk. It has been aptly said that anybody can sue anybody, for anything, because of anything. Real, or fancied, any accidental injury to persons, their feelings or their property is fit subject for litigation against the person and/or persons and/or corporation that the responsibility can be, ever so remotely, pinned on. The "and/ors" are tiresome, but intentionally stressed because of the tendency to designate every conceivable participant in an action. And regardless of the uncertain outcome of any such action, a defense must be entered by competent counsel for each defendant. It is here, also, that hospitals are particularly vulnerable. Not only is the very existence of the physical properties and their alleged deficiencies a cause, but so too is the function performed by its personnel. Psychologically, sick people come to hospitals to be made well and well people come, on one mission or another, and expect to remain well. Any deviation is per se, the fault of the hospital and/or (again) its staff; isn't it?

The potentialities for loss are monumental and completely unpredictable, and there are few firm ground rules, and literally none that are applicable in all jurisdictions. At one time, for example, charitable institutions were almost universally immune from negligence action. This is no longer so. Their inviolability has already been denied in many states and, almost certainly, others will follow suit. This is one instance in which little satisfaction is to be derived from being a "first".

Every piece of physical property, stationary or mobile, and every activity in which an institution engages presents a potential to suit if it can be alleged that damage was done to person or property by reason of its existence or operation. Primarily, it is important to understand the nature of available liability insurance. The company, for a consideration, agrees to do a number of things, any one of which could cost well in excess of the premium. Whether the suit is groundless or not, the insurer agrees to investigate the circumstances on which the claim of the plaintiff is based. It agrees to pay for bonds to release garnishments and attachments, while the action is in litigation. Finally, it

TV modernizes training

How Nebraska Psychiatric Institute uses closed-circuit TV by GPL



Camera observes treatment through one-way window of treatment room without disturbing doctor or patient. GPL camera's high sensitivity eliminates need for special lighting.



Three screens are monitored to select specific treatments for showing to students. Simplicity of design enables any staff member to operate equipment.



Large screen viewing is made possible by unique GPL projection system. Clear, larger-than-life showings of actual treatments are now observed by large classes instead of

small groups. The bright picture gives front-row seats to each of the over 200 psychiatrists and students the Institute's modern auditorium can accommodate.

For further information on GPL **ii-TV**^{*} or name of local GPL representative, write

General Precision Laboratory Incorporated, 61 Bedford Road, Pleasantville, New York

^{*}GPL's industrial-institutional TV system



General Precision Laboratory Incorporated

firmly agrees to pay, if judgment is rendered, up to the limits of the policy. Although not written into the contract, the company for its own advantage conducts periodic surveys to uncover existing deficiencies and recommends corrective measures. All of these activities are conducted by highly competent specialists, familiar by precedents and experience with the cause, cure and defense of negligence actions.

All the foregoing, of course, is contracted for within the terms and conditions and limits of the policy. "Limits", in respect to a hospital, mean two different things, depending upon whether reference is made to general and automobile liability or to professional liability, and careful attention to their adequacy is vital.

Regarding liability arising from the existence of the premises, including elevators etc. and operation of a vehicle, the limits of a policy are expressed as being a given number of dollars payable for liability for injury to any *one* person in any one accident and another number of dollars for *all* those injured in any one accident. The number of times these may be payable in any one policy year is unlimited.

Regarding professional (including malpractice) liability, however, the limits are expressed as being a given number of dollars each occurrence (regardless of number of individuals involved) and another number of dollars, being the maximum aggregate payable during any one policy year. Basic limits under the general liability form are \$5/\$10,000. (\$5,000 per person, \$10,000 all persons, any one accident) and, if one's luck should really be at ebb, the policy would be called upon to pay these limits in any number of successive accidents. Basic limits under the professional liability form are \$5/\$15,000. (\$5,000 per occurrence, \$15,000 maximum in any policy year).

A quick opinion would be to the effect that, since malpractice customarily involves but one person in any one occurrence, the lower limit of the two forms has identical application. The hospital professional policy, however, also covers the dispensing of food, drugs and medicine. Should one batch spoil or be improperly prepared and harm any number of persons, the

injuries are all the result of but one occurrence and the lower limit of the two must be sufficient to cover this contingency.

Limits, higher than basic, are purchasable at percentages of the cost of basic limits and the highest possible limit should be considered. In fact, if the cost of full adequate limits is prohibitive, it would indeed be prudent to consider self-insuring (i.e. deductible) all losses under, say \$1,000 or \$2,500 or some other reasonable amount. Insurers will grant a lower basic rate in consideration of the deductible and the saving can be used to purchase adequate protection at the upper level, where needed most. Losses falling within the deductible may be troublesome and a nuisance but, unless very frequent, will cause no staggering financial burden.

"Forget-Me-Not" Coverage

It is possible to insure virtually any liability hazard to which one is subject—for a suitable consideration. "Second guessing" is, however, ruled out and there must be a complete meeting of minds between insured and insurer, as to precisely what exposures to risk are covered. This may be accomplished by specific liability policies of various kinds, suitably endorsed as the various risks become evident. There are three inherent dangers to this method. The risk might not be recognized, it might not come to the attention of the responsible individual, or it might become the subject of debate, and affirmative action be delayed until too late.

Greatly preferable is the procurement of a so-called "comprehensive" liability policy which, optionally, covers all known insurable hazards existent at the inception of the policy and, for a very nominal additional charge automatically covers any others that may present themselves during the currency of the policy. "Forget-me-not" coverage, we like to call it. If there is no additional risk during term, there is no additional premium and a very few dollars have gone to purchase peace of mind. Should there have been any additional risk, the coverage for it was automatic and it will be charged for upon expiration of the policy. Since the contract is predicated on a full knowledge

of the complete risk as it existed at inception, every effort should be extended to disclose all details of the subject matter of the insurance, for this broadest of available policies is not entirely without its own limitations.

Liability for dispensed products, for example, is customarily excluded by endorsement unless specifically requested. While the hospital professional form includes this coverage, it does so only for products that may cause harm to its patients. It is not unusual for a hospital to maintain a gift shop and restaurant for the convenience of visitors. Liability for products dispensed to them must be covered under the general liability form. The problem of an adequate annual aggregate limit on products liability claims will rear its ugly little head again here, and the counsel of your insurance advisor should be heeded.

There is no institution without some form of automobile liability exposure. Owned automobiles, whether passenger cars, pickup vehicles or ambulances, present an obvious exposure. Less readily recognized is the circumstance that one may be assessed for bodily injury or property damage if inflicted by a vehicle, operated by anyone, whether regularly or not, and whether for a remuneration or not, if the operator is on a mission for you at that time. This is an intentionally broad statement, but warranted by countless circumstances that have come to attention.

If an automobile policy is in existence covering an owned automobile, it should be suitably extended to include non-ownership liability for the operation of automobiles in the employer's service, by all employees and for hired vehicles, if any. There is a nominal charge for employees and none for hired vehicles, unless actually hired. If there are no owned vehicles, a separate policy is available.

In this field, too, the "comprehensive" automobile form of policy is the ultimate protection and, if a "comprehensive general liability" policy is also had, the two can be neatly wrapped up into a single, all inclusive policy respecting premises and vehicle hazards. Although professional liability may also be endorsed to such a contract, the limited num-



Restraint...in a pleasant and friendly way!

Fenestra® Psychiatric Package Windows combine advanced detention features with pleasant, friendly "regular window" appearance.

There are no bars. Yet your patients are fully safeguarded. The inside guard screen keeps patients away from the window and window glass. The screen is installed flush with the casing to eliminate ledges that invite climbing or tampering. The window operating equipment is concealed, but ventilation is easily adjusted without touching the screen.

Each Package Unit consists of a Fenestra Awning Window, operating hardware with removable adjuster handle, metal casing and

choice of a Detention Guard Screen for maximum restraint, a Protective Guard Screen for milder patients, or an Insect Screen for nonrestraint areas.

Fenestra Awning Windows are easily installed, blend with any style of architecture and may be used *throughout* your buildings with or without Guard Screens. This makes it possible to expand or move psychiatric wards, as needed, by simply adding Guard Screens or removing them. Mail the coupon today for complete information.

Fenestra

INCORPORATED

**PSYCHIATRIC
PACKAGE
WINDOW UNIT**

YOUR SINGLE SOURCE OF SUPPLY FOR
WINDOWS • DOORS • BUILDING PANELS

Fenestra Incorporated

M-6, 3453 Griffin St.
Detroit 11, Michigan

Please send me complete information on Fenestra Psychiatric Package Window Units.

NAME _____

HOSPITAL _____

ADDRESS _____

CITY _____ STATE _____

ber of insuring companies in the malpractice field may make this extension difficult to accomplish.

It is reemphasized that specific coverage can be had and will provide protection within the limitations of each policy but there is apt to be some overlap and certain to be some gaps; it is reasonably safe to venture an opinion that no combination of specific policies will add up to that which is afforded by a single comprehensive policy. Furthermore, due to the idiosyncrasies of rating procedure, a review of a substantial insurance program will reveal the possibility of accomplishing the goal at no overall increase in cost.

In the realm of liability insurance there exists a vast twilight zone surrounding the liability of the staff and the administrators who direct its activities. And, here is where "and/or" again enters the picture. Attorneys for plaintiffs endeavor to join in suit every available person associated in any way with an alleged concurrence.

It is not unusual to cite the director, resident physician and any intern who may have been in attendance in an action against the hospital, occasionally a nurse and, in at least one instance within our knowledge, a member of the maintenance staff.

The professional liability policy of the institution insures the liability of its proprietor, the members of a partnership or its corporate liability and includes coverage for any executive officer and (corporate) director for their liability arising out of the activities of the hospital, but does not agree to defend or indemnify the individual professional liability of any of its employees. It is a disconcerting problem to a young man or woman venturing on a professional career to be confronted with such an incident and, in the absence of proper defense, it may be ruinous to their future. Generally speaking, an individual cannot procure this insurance and, if it were available to him, the cost would be prohibitive in relation to his limited

income. Many institutions have procured at their own cost a blanket policy insuring the liability of interns, residents and fellows and, in some instances, nurses.

In the same vein, the administrative staff—directors and supervisors—occupy a unique, and something of an unenviable position in respect of their professional liability. Their financial circumstances and their medical society affiliations make available to them a personal malpractice policy which will cover customarily only acts committed by them individually, and usually excludes liability that inheres in them by reason of the acts of another. The normal, every day routine of the position occupied demands the supervision of an indeterminate number of staff personnel. Their exposure to loss can best be expressed in the formula: director times number supervised times number of patients, times number of visits or drugs dispensed plus the number ministered to by the

LOOK IN THE BROOM CLOSET, DOCTOR

By Dr. Whatsisname

IF YOU GIVE this issue a once-over-lightly you might get the impression that it is strictly for engineers, housekeepers and business managers. After all, you did go to



medical school and do graduate work and all that, so it does seem wasteful to divert your precious cortical cells to the consideration of budgets, bills, or broom closets.

Maybe in a general hospital the physician can indulge in that kind of aloofness. The general hospital is a hotel for sick people, and what with early ambulation, wonderdrugs, and Blue Cross investigators, the average patient doesn't stay in that hotel long enough to be much affected by its climate. But the public mental hospital is a city of the sick, a community, an environmental bath in which the patient is totally immersed. Living for weeks in a poorly lighted ward does make an impact on your mood. Hospital clothing can be so ill-fitting or so grotesque as to strip all dignity away from the patient who wears it. An indifferently dirty attendant or a compulsively clean one can, each in his own way, warp the patient who is subject to his tyranny. Sloppy food can be more demoralizing than food deficient in vitamins. Anybody—even you and I—can be enervated by a ward that is constantly overheated because of poor thermostat control.

So there is no frontier between the purely "medical" side of psychiatric patient care, and its maintenance, housekeeping or engineering aspects. The "pure" psychiatrist may throw away this issue, for by reading it he will contaminate his purity.

But, among physicians, the "whole" man is interested in the whole patient. So read what is written here about linen, locks and laundry. For indeed, as Lord Bacon says, "Reading maketh a full man." A good psychiatrist cannot afford to be a part man.

director—an amoeba-like progression. The resulting figure represents the number of exposures to which a director is subject and, though actual liability may be remote, it is much greater than contemplated at the premium chargeable for a personal malpractice policy.

Insurers, generally, refuse to grant this coverage except at a cost that would make it prohibitive to an individual. If the liability of directors is to be covered, it can be accomplished, with the insurer's consent, by an extension to the professional liability policy of the hospital in the service of which the director is subjecting himself to this liability. Nomenclature can be confusing and, if coverage is secured, it should especially differentiate between directors (corporate) and directors (professional).

Good Safety Regulations Reduce Cost

Workmen's Compensation insurance, including employers' common law liability, is one of the "must" coverages. The terms and conditions applicable to the compensation policies written within any given state are fixed by the statutes of that state and neither insured nor insurer can deviate from, at least, the minimum requirements. Particularly in the instance of larger institutions, however, rates may be subject to credit or debit rating based upon claims experience and, in these instances a carefully conducted survey of working conditions should be made with a view to the elimination of any that may be productive of injury to workers. Proper safety regulations can be a potent means of reducing premiums or avoiding a debit rate. One other aspect of compensation insurance, somewhat peculiar to hospitals, is the circumstance that coverage may be granted including or excluding medical services. There is approximately a 20% differential on the theory that the insured institution can, itself, provide the necessary medical or surgical care at a lesser net cost than the insurer would become obliged to pay. This is generally true, but while an employee may be wholly content to work in a given environment for a wage, he may not choose to be treated there and, where the injured employee has the absolute right to select his practitioner, medical expenses could attain

sizable proportions. Companies exercise considerable discretion as to those for whom they will grant medical coverage and, in instances in which they will, the premium differential is of some consequence. Nevertheless, and particularly to a proprietary institution, available facilities are at a premium and the question as to which form is the more advantageous turns wholly on the exigencies of each situation.

The insurance industry is state regulated and rates and rules differ from state to state. The law of negli-

gence varies similarly. No two institutions are likely to have identical exposures. Even a reasonably comprehensive treatise on any one of the forms of insurance mentioned would require vastly more than the space available here. It must be reemphasized that the foregoing is, of necessity, a skeletonized and highly generalized version of the subject, and determination of the right program in any given instance turns on a complete and knowledgeable survey of the exposures to which each institution is subject.

NEW TYPE MATTRESS Receives Acclaim of Hospital Managers

After 3½ years actual service in hospitals all over the country, under every type of severe service, the superiority claimed for the SYKO-ETTE Mattress is fast being substantiated by reports of actual service records.

These records show that the SYKO-ETTE Mattress is now winning enthusiastic approval of hospital management for COMFORT, DURABILITY, EASE OF SANITIZING, and LOW COST PER YEAR OF SERVICE.

The covering material is made of a special weave nylon, coated with a special neoprene compound. This neoprene compound contains only pure paraffin-type hydro-carbon materials, resulting in a soft, pliable, tough, durable cover that is compatible to the skin. It adjusts itself to room temperature and body temperature, and does not create the irritating heat of rubber sheets and plastic covers. SYKO-ETTE covering has shown by far the best results in laboratory tests, of any material made, for wear, imperviousness, flex, tear strength, pressure resistance, and all other tests made on materials used for covering mattresses.

Every hospital is interested in holding costs down. With SYKO-ETTE Mattresses there are no rubber sheets or plastic covers to buy, inventory of reserve mattresses can be reduced. SYKO-ETTE Mattresses outlast others to the extent of saving the

replacement cost of three to five mattresses of any other type.

Nurses and attendants especially appreciate the convenience of SYKO-ETTE Mattresses because of the time saved and reduction of hard work. Sheets do not crawl or wrinkle under a patient's body. Beds do not need to be remade so often. The SYKO-ETTE Mattress works perfectly on a gatch bed and elevates without slipping. There are no buttons, humps, or lumps. The sleeping surface is smooth and comfortable to aid in quick recovery of patients.

SYKO-ETTE Mattresses are waterproof, quickly cleaned with soap and water and wiped dry for immediate re-use. They will not retain odors, and are always fresh and sanitary again after cleaning. They are fire-resistant and impervious to body fluids and wastes, disinfectants, deodorants, and resist most acids.

The SYKO-ETTE Mattress is made in a choice of three types of inner construction. One type has a special rubberized hair pad encased in thick layers of stitched cotton felt. Another has Foamex rubber with center stiffener pad. The third has a specially designed innerspring unit.

Every construction feature has been tested and improved until today SYKO-ETTE Mattresses are without equal. You can recommend or buy them with complete confidence that they are now the best buy on the market.

Return This Coupon For Complete Information On

----- Syko-ette MATTRESSES -----

THE BALYEAT CO., Dept. MH-67, 481 North Main St., Mansfield, Ohio

Please send me complete information on SYKO-ETTE Mattresses.

Name _____ Title _____

Institution _____

Street _____

City _____ State _____

LOCKS AND KEYS

By AARON S. MASON, M.D. Director, Professional Services
Veterans Administration Hospital, Brockton, Massachusetts

KEYS MAY BE DESCRIBED as items that employees of a mental hospital use every day and about which almost complete silence is maintained. The literature is quite barren about this subject. In most of the published articles on architectural design which describe in detail the plans, furnishings, and equipment for the most modern psychiatric units constructed, no mention is made about locks and keys. In the rest, the topic is disposed of with a sentence or two.

Yet keys are important symbols of power, responsibility and ownership. Stanton and Schwartz have noted that to the mental patient, the key is the most significant symbol of his helplessness. It is viewed as a token of the whole structure of power and responsibility in the mental hospital. While remarks from patients about the differences between those who have keys and those who have not are relatively infrequent, when they do occur their affective content is great. We have observed that when a patient embarks on member-employee status and is processed in the same manner as any other new employee, the most striking emotional reaction occurs when he is given his keys. "Do I get a key to keep?" is the first and most common question asked.

Administration of keys has sometimes gone to ridiculous extremes. At one hospital the nurse supervisor is given a key ring containing over one hundred keys. This key ring is not only too large to fit in a pocket but is too heavy to carry except for a short distance. In most hospitals a nurse, relieving on the evening shifts, requires several bunches of keys in order to make her appointed rounds. Rubber bands are necessary to hold together the seldom used keys on the key ring. It is no wonder that the sagging, frayed, key-laden uniform pocket has become the badge of the psychiatric nurse.

Our experiences at this Haun-type, 1,000-bed hospital, opened late in 1953, have led us to the conclusion that the cardinal principle of key administration is simplicity. This means furnishing employees with as few keys as possible to insure efficient and effective operation throughout the hospital.

Time Saved for Patient Care

The Chief Nurse Master key might well be called the "key" to our whole simple system. Every nurse, every nurse supervisor and every psychiatric aide carries this key, which opens the nurses' station, treatment rooms, doctor's office, nourishment kitchen, linen and supply closets, clothing room and occupational therapy and game closet in every ward unit of the hospital. They also carry a bit key which permits access to all patient buildings and wards, aide locker rooms, staff toilets, corridors and other general areas. On the ward units, this key opens the dayroom, dormitories, visitors' room, shower room, toilet section, janitors' closet, small utility rooms and the fire equipment closet.

The psychiatric aide starting employment is issued the Chief Nurse Master key and a bit key, and their safekeeping becomes his responsibility throughout his period of employment. If he loses them he must pay for the cost of replacements. In addition he receives a key ring and a snap key clip which is attached to a brown leather thong. The leather thong enables him to secure the keys to his belt while the keys are kept in his pocket. The use of metal key chains for this purpose is prohibited. We are in the process of replacing the brown thongs with white ones so that this feature will blend more inconspicuously with the white uniform of the aide.

Initially, the hospital was supplied with nursing unit keys which opened the same rooms as the Chief Nurse

Master key but only in the nursing units on one floor of a building. Each head nurse would draw from supply division about ten to twenty-five nursing unit keys for her particular ward. When an aide came on duty he was issued a nursing unit key by the nurse which he turned in at the end of each tour of duty. In the event of reassignment to another ward during his tour of duty, the aide had to turn in the nursing unit key on the first ward and pick up a different key on the second ward. Aides called to a ward from another area in the event of an emergency were often unable to function effectively until a nursing unit key for that particular ward had been obtained from a nurse.

Our present system of key administration, based on the Chief Nurse Master key, eliminates these disadvantages. Moreover, it was hypocritical to maintain that the psychiatric aide was, in many ways, the most important member of the treatment team and at the same time indicate that he could not be trusted with the same keys as the rest of the employees on the ward units. Now all members of the treatment team have the two keys that enable them to perform their duties efficiently on any ward unit in the hospital. The morale, prestige and self-esteem of the aide has been raised and he has recognized his responsibility in safeguarding his own keys more keenly than ever before. The time saved by the nurse and aide in issuing and collecting keys during each tour of duty can be devoted to patient care. There are fewer keys floating about the ward units and the nurse, relieved of the responsibility of looking after a large number of keys, can focus her attention on more pertinent duties. Needless to say, we consider archaic the system of a large key board filled with dozens of sets of keys and located at a central point where aides pick up a set of keys, sign a key book at the beginning of each tour of duty, and go through the same procedure when going off duty.

One Key to "Luxury Cabinet"

When this hospital was opened Chief Nurse Master keys were issued only to nurse supervisors. Any other nurse covering a building during the afternoon or evening shifts required as many nursing unit keys as there

were wards in that building. Each nursing unit key had to be tagged so that it could be identified with the proper ward. The procurement and issuance of Chief Nurse Master keys to all nurses considerably reduced the number of keys that any nurse is required to carry on her person.

The medicine cabinets in the nurses' station throughout the hospital are individually keyed; thus, a separate medicine cabinet key is required for each ward unit. A more ideal situation would have been possible if all medicine cabinets procured for the hospital had been keyed to one key. While, for the day nurse, this usually means only one key, the afternoon and night nurses require several, one for each medicine cabinet in the ward units to which they are assigned. These nurses are given a separate key ring containing keys for the medicine cabinets of the ward units they cover. The narcotic boxes within each medicine cabinet must, perforce, be individually keyed.

The luxury closet, with space compartments for each patient's canteen book, cigarettes, candy and other incidentals on the ward unit, is keyed individually. The ward nurse has the responsibility for this key and she may delegate to aides duties involving luxuries. Most of the patients are aware that there is but one key to the luxury cabinet, and appreciate that their personal possessions are being properly safeguarded. Rarely do they doubt the nurse's word as to their property in the closet. When not in use, this key is kept locked in the medicine cabinet.

The nurses' station is glass-enclosed and adjacent to the day-room. There is more traffic through this door by members of the hospital team than at any other non-patient area. As constructed, the locks on the door of the nurses' station were the dead lock type. This made it difficult for a nurse, carrying a tray and leaving the nurses' station, to fish the key from her pocket to lock the door. By removing the dead locks and installing snap locks so that the door locks automatically when closed, this situation has been corrected. In addition, the number of times personnel use their key on this particular door in full view of the patients has been reduced by 50%. Snap locks would also be preferable

to dead locks in the linen rooms, treatment rooms, doctor's office and nourishment kitchen.

Every patient has an individual clothing locker and privileged patients are given a key to their locker. Originally, the nurse in each ward unit maintained a complete set of duplicates for use in case a patient lost his key. Each ward now has a Locker Master key. The duplicates have been turned over to the hospital locksmith who furnishes a new key to the patient who loses his locker key.

The clinics of each section of the Physical Medicine & Rehabilitation Service (Occupational Therapy, Cor-



rective Therapy, Manual Arts Therapy, Educational Therapy and Physical Therapy) are separately keyed. Rather than install buzzers or chimes on the doors to call the therapist to open the door for a visitor, a bit key lock has been installed above the regular lock. Thus, all members of the hospital team have easy access to the clinics when patients are present and the feeling of being "shut out" from these areas is eliminated. The same procedure has been followed in Special Service areas such as the gymnasium and libraries.

Selected patients, after clearance by their ward physician, are permitted to use whatever keys are necessary in carrying out their Industrial Therapy

assignments. The work supervisor provides them with keys on a day-to-day basis which are turned in to the work supervisor before patients leave their assignment to return to their ward. We have observed marked improvement in some patients when they are given the recognition and responsibility of handling keys. No untoward incident has resulted from this policy although it has been in effect ever since the hospital opened.

The supply division issues keys to an employee at the written request of a chief of service or division. This division maintains a special cabinet with numbered hooks for about 1,200 different keys, an original of every type of key used in the hospital. These are removed only when the locksmith requires a sample to make duplicates and are then promptly returned to the cabinet. Three separate registers are maintained here: by 1) name, 2) room number, and 3) hook number. The locksmith notifies the supply clerk of all changes of locks and keys and the room numbers involved so that the records are always accurate.

In future hospital construction, it is recommended that ease of procurement and prompt delivery of replacements of lock hardware be carefully investigated before contracts are awarded for this item. During our first two years of operation, we experienced inordinate delay in obtaining the hardware necessary to effect any lock changes. At times there was a waiting period of over six months. It is our understanding that some of the major lock manufacturers will not sell directly to a hospital and that replacements must be purchased from a distributor. This problem has been alleviated since we induced a local distributor to carry a stock of replacements commonly needed.

At this hospital, the number of patients on privileges (open ward status) has doubled during the past two years and, at the present time, almost 50% of our patients have been approved for privileges by the medical staff. With the elimination of the concept of custody and control, and acceptance of the trend of the open hospital, the problem of locks and keys will diminish in importance in mental hospitals. Then, as in the common household, locks and keys will be used mainly for the protection of property.



Oswatomie State Hospital,
Oswatomie, Kansas.
Charles L. Marshall, architect;
Martin K. Eby Construction Co., contractor.

HOSPITALS ARE LIGHT, BRIGHT, CHEERY with Truscon Detention Windows

Look at this handsome window arrangement and at the attractive landscape it frames. You'd hardly believe that these Truscon Steel Intermediate Louver Windows provide detention. But, they do . . . to the degree that you require.

For example, you can have this Truscon Window with 100% ventilation and restraint provided by detention screens. It is particularly suited to the needs of mental hospitals. A similar design provides fixed meeting rails that limit vent opening to 5¼ inches. This is suitable where moderate detention is required.

Truscon designs all detention windows to the

idea that it is important not only to protect mental patients against self-injury or escape, but that every indication of enforced restraint be concealed or minimized.

In this category, Truscon offers an unusually complete line of proved designs to provide adequate light and ventilation for mental patients. Truscon window engineers will help you and your architects select the proper Truscon Steel Windows for your geographical location, type of building, and degree of restraint required. Write for the complete Truscon Window catalog for your files.

TRUSCON®



TRUSCON STEEL DIVISION REPUBLIC STEEL

1112 ALBERT STREET • YOUNGSTOWN 1, OHIO
Export Dept.: Chrysler Bldg., New York 17, N. Y.

A NAME YOU CAN BUILD ON

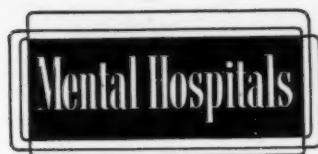


ARCH

H O
t
hospit
cessive
maint
electri
losses
your
large?
questi
admin
gineer
world

Yes
nance
excess
specti
pipes
other
and in
by ac
will c
plant
good
is lim
yond
equip
stalle
to the
tions
layed
ment
in th

N
For
room
overh
steam
ten f
in m
astric
Just



Preventive Maintenance Begins with Design

By ALBERT MILLAR, JR.,
 Director, Engineering and Maintenance
 Eastern Penna. Psychiatric Institute, Philadelphia

HOW MUCH ARE YOU spending to repair and maintain your hospital buildings? Are your costs excessive? Why so many men on the maintenance payroll? Are you having electrical motor burn-outs? Are your losses from fire a trifle high? Does your replacement of piping seem large? These and a hundred similar questions plague medical directors, administrators and maintenance engineers in hospitals all over the world.

Yes, a good preventive maintenance program will materially reduce excessive costs. Constant routine inspections—of electrical fittings daily, pipes and steam fittings weekly, and other equipment every other week—and irregular unscheduled inspections by administrative department heads will do much to keep equipment and plant in mint condition. But even a good preventive maintenance program is limited in its ability to cut costs beyond a certain point. If mechanical equipment is so designed and installed as not to be readily accessible to the maintenance mechanic, inspections may be skipped and repairs delayed. While the initial cost of equipment may be reduced, maintenance in the long run will prove costlier.

Needed: Mechanically-trained Chimpanzees

For example, in many mechanical rooms main steam valves are placed overhead at heights that require a steam fitter to perch atop an eight or ten foot ladder to work on the valve; in many cases he will have to sit astride another steam main to work. Just to repack the valve he loses con-

siderable time in getting up and down or he must have a helper standing by to hand him tools and packing and lubrication. But let's suppose that during construction the valve and main had been placed on a wall four or five feet from the floor. One steam fitter could do the work without "aping" around on a ladder or on another steam main; he would be in a comfortable position to work at his highest efficiency, making better and more accurate cuts on the packing, cutting waste and possibly deferring the next replacement of packing.

This same reasoning can be applied to the pipe spaces all over your buildings, particularly where advanced architectural and mechanical designs have placed one toilet room adjacent to another, providing space between to utilize one system of supply risers. While this cuts construction costs, in ninety-nine percent of the cases the design has failed to provide for maintenance procedures. The piping is arranged with the main in the center of the pipe space with laterals to lavatories and toilets about two feet from the floor. When a plumber must get to that back flushometer to stop continuous running, he must actually straddle the center main and laboriously work his way over all the laterals, carrying equipment, swaying from side to side with not enough knee room to bring one leg in front of the other. Many mechanics yield to temptation and step on the small size piping—with costly results. Here again, parts cost may be at the minimum but time and labor and pipe replacement are definitely not. How much better to have spent a little

more in piping from feed headers and laterals near the floor, making a step of only four or five inches necessary. This would remove the temptation to walk on the small piping; it would also save much time getting to the trouble. The additional costs during construction would, I feel sure, be amortized through savings in the first five years of operation. Better than being burdened with excess labor and piping costs for forty or fifty years of operation!

Circuit Breakers Save Fires

Have you had an epidemic of drapes catching fire, a rug seared and charred, or a radio "go up in smoke"? All these are probably traceable to worn, frayed and bare-spotted electrical cords. Even though your fire marshal or electrician makes monthly inspections of the fuses in the lighting and power panels, there is always somebody who will improvise a fuse link from a bit of tin or stranded wire, thus causing overheating at the worn places and resulting in these costly little fires. No matter how good your preventive maintenance checks are, this will continue to happen. This same practice of plugging the fuses will overload the wiring and cause insulation breakdown—and more untimely replacements result. The installation of circuit breaker panels at the time of construction would have avoided this needless loss.

The normal life of a good electrical motor varies, but in general the motors installed in hospitals should last ten, fifteen and even twenty years, if they have been properly sized, and if a good maintenance program keeps

them lubricated along with the driven equipment. However, if the maintenance mechanic in lubricating forgets to properly check one bearing, that bearing will soon create an extra load on the motor and cause overheating and drawing of amperage considerably in excess of the ambient temperature on the motor. This results in insulation material breakdown and the motor burns out.

These conditions can be corrected. However, the starting torque invariably requires 200 or 300 percent of the full load amperes of the motor. If fuses only are used, the fuse link must be heavy enough to take the starting amperage so that the motor can operate at temperatures far above that allowed by the ambient design. Otherwise burn-outs will occur. The time-lag fuse must be slightly higher than the full load ampere rating on the motor in order to protect the motor. The best known method is the use of thermal overloads in across-the-line starters for all motors. It costs a little more, but is very much cheaper to operate over a period of years.

So we must come to the conclusion that even a very successful preventive maintenance program is not the last word in saving maintenance costs. Good, foresighted design is basic in the reduction of preventive maintenance costs.

The Best Laid Plans—!

Would you say, for instance, that a small field mouse could cost you three thousand dollars, and twelve hours without electrical services? It actually happened at a large school for mental defectives, and all for the lack of a \$2.00 item—a plug missing in a three-inch conduit around the high tension conductors leading out of a switchgear cubicle. At 2 A.M. on February 12, 1953 a mouse entered the cubicle through the conduit from the transformer vault and got across two untaped high tension terminals, naturally electrocuting himself. This caused an electrical fault resulting in continuous arcing and a tremendous flow of carbon particles which coated the entire inside of the cubicle, destroying terminal bolts, terminals, cable ends, and sections of buss bars. Because the fault occurred ahead of the breakers in the switchgear cubicle, both feeder breakers at the sub-station

were tripped, thus plunging the entire institution into cold and darkness. It was necessary to disconnect both feeder potheads in the damaged cubicle, clean both, tape off one, and run 5,000 volt conductors direct to the transformers to put electrical service back into the building. The entire institution was without current for one hour and fifteen minutes, and the two buildings serviced from the cubicle were out of service for twelve hours. This switchgear is one of the better quality, manufactured by Manypenny in Philadelphia and has been giving excellent and efficient service since the day of installation.

However, one little plug forgotten in design against vermin resulted in this major breakdown.

In modernizing the laundry building at the same institution, the transformer vault, switchgear equipment and main distribution secondary panel were placed below grade at the lowest point in the new excavations, with a sump pump provided to handle drainage from this area with power supplied from these transformers. A four-inch copper water main came apart at a soldered sleeve and submerged the transformers and switchgear in about 18 inches of water. The water came into the vault area too



The value of a chimpanzee
To reach this valve is plain to see!

fast for
ume;
and a
forme
rent a
damag
for m
matel
major
cause
in ov
and s
finger
main
thing
pen
vaults
panels
out a
Furth
ventil
alway
Th
ers, s
panels
avoid
adver
and b
this p
ing f
ularly
be ob
medic
patien
instit
mecha
cessib
archit
invari
how r
patien
cal co
leads
areas,
ginee

Corre

Du
Penn
which
rector
archi
cal a
sever
an ef
train
woul
and
also
and l
resul
extre

fast for the pump to handle the volume; naturally a trip-out occurred, and as a result one 75 KVA transformer grounded. It was necessary to rent a transformer and then ship the damaged transformer to the factory for repairs, at a total cost of approximately \$1,000. Not too costly but a major breakdown was avoided only because the dual feeder potheads came in overhead. However, the engineer and superintendent are keeping their fingers crossed that another water main doesn't break and the same thing happen again. And it can happen and will where transformer vaults, switchgear and distribution panels are placed below grade without adequate free drainage to grade. Furthermore, moisture and improper ventilation of these below-grade vaults always present serious problems.

This practice of placing transformers, switchgear and main distribution panels below grade is intended to avoid the possibility of patients' inadvertently gaining access to them and being seriously hurt. It is well at this point to indicate that in designing for psychiatric patients, particularly the ambulant, practices must be observed that are not needed in medical-surgical hospitals where few patients are out of bed. In psychiatric institutions it is mandatory that much mechanical equipment be kept inaccessible as far as possible. Design architects and mechanical engineers invariably have endless discussions on how much space must be taken from patient areas for the proper mechanical construction. This is a battle that leads to some cramped mechanical areas, thus giving the maintenance engineer serious problems of repair.

Corrections Costly, but Worth While

During the planning of the Eastern Pennsylvania Psychiatric Institute, which opened in 1956, the Medical Director, Dr. John E. Davis, Jr., the architects and the mechanical, electrical and electronics engineers spent several years of intensive research in an effort to design and construct a training and research center that would allow superior care of adult and child psychiatric patients, and also be functional for both clinical and basic training and research. The result of their efforts has produced an extremely efficient plant, avoiding

the evils of traffic problems for outpatients and inpatients, adults and children. However, certain mechanical areas were not planned large enough to house all the equipment and piping that it was necessary to install, with the result that inefficiencies in operating became extremely noticeable. Most of these conditions became apparent during construction, but because the building was being constructed according to plans and specifications, nothing was done to correct them. When the time came to accept the building, however, these exceptions were brought to the attention of the architects and mechanical engineers, and the work to correct them was approved at a cost of \$20,000. This is a very small percentage of the entire cost of the Institute, but had these items not been corrected as construction costs, the first year's maintenance costs would have been extremely out of line. Had they been corrected during actual construction the cost could have been reduced to about \$5,000.

Faulty Ventilation Makes Trouble

Corrections needed consisted mainly of ventilation of three different rooms—a pent-house mechanical room which was exposed to the sun on three sides; a below-grade mechanical room near the ceiling where ninety percent of the steam piping, valves, regulating valves and relief valves were located; and a small refrigeration compressor room that was below grade without any ventilation whatsoever. These rooms consequently had excessive temperatures which could not be reduced; as a result, the refrigeration compressors cut-off on high side pressure switches, and the temperature in the below-grade mechanical room was 120° F., in which a man cannot work with safety. Radiant heating expansion tanks in the mechanical rooms proved to be inoperative and extra expansion tanks had to be installed at the top of the system.

A catwalk had to be put in the below-grade room to give access to a small portion of the most important shut-off valves, and additional access doors to pipe spaces had to be installed in different locations because the existing doors to pipe spaces were blocked immediately inside by large water and drainage mains. Moisture

on the floors of the mechanical rooms from the packing drips of the circulating pumps was attacking the pipe supports, the electrical conduit and the supports for the electrical controls. Piping had to be installed to take the drops to a drain and a new floor drain was required.

The ventilation of the laundry room was also inadequate. Door butts with increased throw had to be procured to avoid striking the terrazzo cove base, thus ripping the butts from the doors or damaging the door stiles.

General Design Suggestions

From an architectural and design viewpoint, these items may sound relatively unimportant. But any mechanical engineer will readily understand that without correction, these faults would very materially have increased the maintenance cost of replacements of electrical conduit and wiring, of supports damaged by rust and erosion, and of motor breakdowns from excessive temperature for many years to come. No matter how good the preventive maintenance program, these replacements could not have been avoided.

We find other items of design and specifications that should be carefully considered if maintenance costs are to be kept to a minimum. Ceiling access panels, for instance, should be big enough to permit easy lubrication of automatic dampers in ducting; there should be easy access to supply and exhaust fans on laboratory fume hoods, to bleed cocks in radiant heating floor coils, to ceiling piping shut-off valves and to similar mechanical equipment. Walls of ceramic tile instead of plaster (and why not in a cheerful pastel color?) and base coves of ceramic instead of rubber strips will eliminate painting and greatly reduce maintenance costs. Surely many such items can be recognized in your own hospital.

Ask the Maintenance Engineers Early!

Getting the advice of an experienced maintenance engineer at the design stage, or permitting the engineer who will be responsible for operating the building after construction to review the specifications and plans before final approval, would result in reducing quite a few maintenance costs to THE minimum.

Planning an Efficient Laundry Department

By A. L. CHRISTENSEN, Manager and LEE G. JOHNSTON, Laboratory Division Manager,

Department of Production and Engineering
American Institute of Laundering, Joliet, Illinois

THE OPERATION of a laundry by an institution provides a service department incidental to the main purposes of the institution. This frequently results in failures to recognize or understand the many factors involved in the operation of a laundry for the best service at the lowest cost.

Laundering is more than the mere washing, drying and ironing of clothes. It is an industrial process that calls for all the planning, organizing and control which permits success in any industrial activity.

Every laundry operation needs periodic review. In fact, it has been found to be highly practical to call in specialized laundry consultants for a professional diagnosis of the laundering and related activities. With or without such consulting service, it is important that the superintendent and business manager of an institution be reasonably familiar with some phases of laundry management.

Location and Lighting of Plant

The laundry should be in a location that requires a minimum of transport—pushing trucks—of soiled and clean linens from and to the points of use. The costs of long transports can be substantial. The time during which linens are tied up while being transported may cause delays in scheduling work.

The room in which the laundering is done should have adequate lighting and ventilation. These are necessary to good working conditions for employees. They are of increasing importance as inducements for people to work in the laundry.

Linens are subject to stains. The entire laundry should permit detec-

tion of any stains. This means lighting both adequate and of a type that makes the stains at least as noticeable there as in any other part of the institution.

The same principles apply to lighting for the purposes of observing any shadows on fabrics resulting from poor ironing. Otherwise, faulty ironing may not be observed until the linens are received in other areas where there is good lighting.

Machinery Requirements

Any evaluation of the machinery requirements in an institutional laundry should consider at least three important factors. The first factor is the actual work load in the laundry. There are published average figures by types of hospital or institution to indicate the average laundry work load in terms of pounds per patient day. These are average figures; they do not indicate the load in any one institution.

Averages may be the only available figures in planning a new institution. In an institution that is already in operation, it is a simple matter to determine the actual weekly load by three important categories: 1) tumbled dry; 2) ironed flatwork; and 3) press work. These can be weighed and the totals for each category arrived at at the end of a calendar week. The total weight provides a basis for determining the amount necessary to wash, and some indication of the number and sizes of washing machines desirable.

Another consideration must be the number of hours the laundry is to be operated to process this work load. Although the actual use load is dis-

tributed over a seven-day week, the operating hours of the laundry department are seldom more than six eight-hour days. The trend is definitely in the direction of a five-day week of forty hours. It is believed that this is the number of hours on which the equipment and other laundering facilities should be based.

When planning the machinery requirements for a mental institution, one cannot overlook the institutional policy concerning the extent to which the laundry is to be used for industrial therapy. There should be a policy regarding the percentage of patient labor to be used and the percentage of employed labor. Experience seems to indicate that the laundry is operated most economically by the use of 100% employed labor. In other words, using the laundry for therapeutic purposes tends to reduce efficiency.

Plant Layout

Any plan for a new layout of an existing laundry department should begin with a study of the present arrangement of equipment. A good way to approach this is to prepare a scale drawing of the laundry department floor space showing the location of each piece of equipment. Then trace the flow of work through the plant from one operation to the next. A separate color pencil for separate flow lines can be used for showing different classifications of work, such as flatwork, tumbled work and press work. This can be most reliably done by actually making observations in the laundry department, following the movement of the work loads through the laundry.

Watch for cross-flows, back-tracking, exceptionally long transports and excessive storages. Cross-flows are where the flow of one type of work crosses the flow of another type. This tends to produce confusion and should be kept to an absolute minimum; preferably, it should be eliminated entirely. Back-tracking also produces confusion and results in unnecessarily long transports. Exceptionally long transports, particularly of wet, heavy material, are expensive.

An effort should be made to eliminate storage of work. Excessive storage uses valuable floor space, which could otherwise be used for more productive purposes. It increases the overall time to process a load of work through the plant.

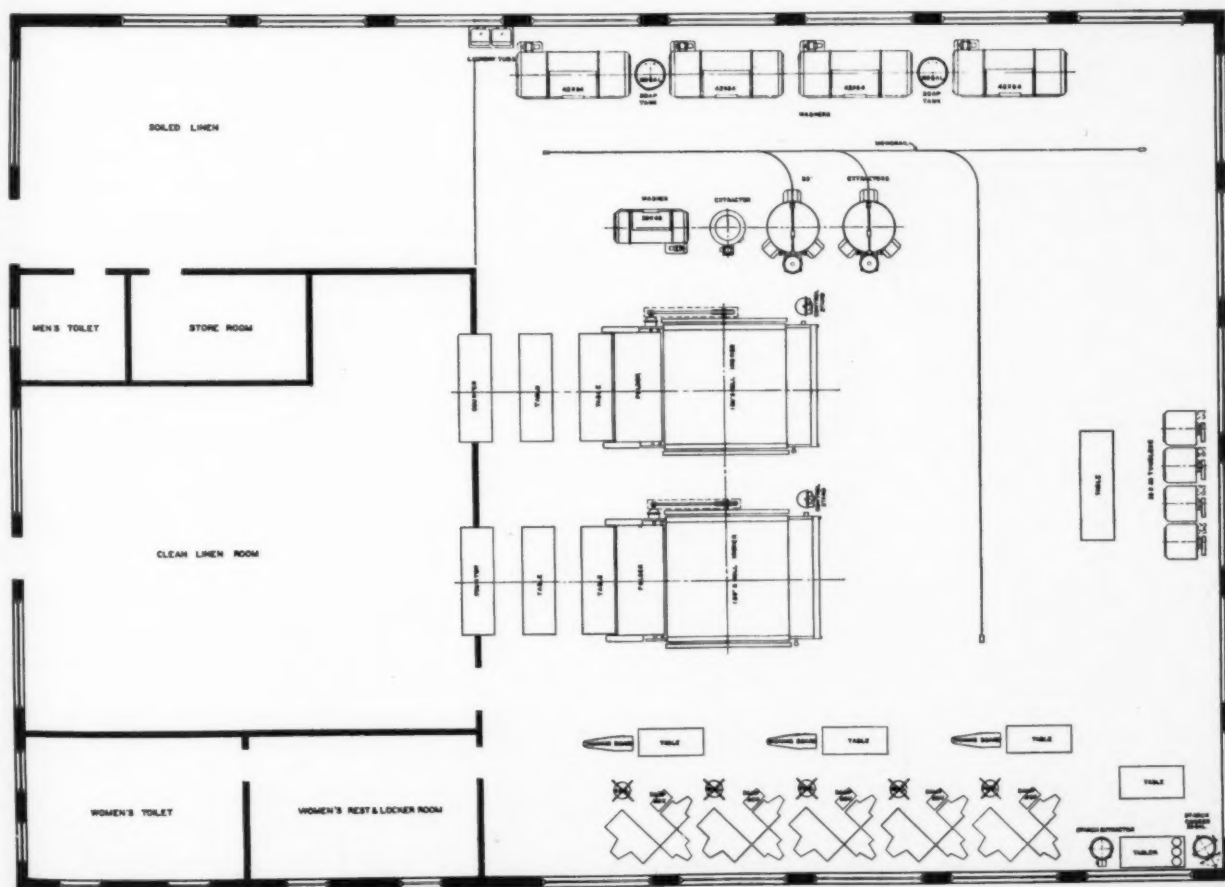
With the present layout thoroughly analyzed and its weaknesses and errors located, work may be started on the new layout. Here again we

start with an outline drawing of the available floor area or areas. Placement of machinery is projected with scale-drawn templates representing each piece of equipment. These templates are available from machinery manufacturers and from the American Institute of Laundering to its members. These templates are drawn to a scale of $\frac{1}{4}$ inch to 1 foot. They are on heavy paper which can be cut out and moved around on the drawing as may be desired.

Strive for a straight line flow of work, with the soiled work starting at one end of the plant and flowing in a direct line to the linen room at the opposite end. Some plants are arranged so that the work flow is approximately in the shape of a "U". This arrangement makes it possible for the soiled work to come in and the finished work to go out at the same side of the building.

The accompanying drawing shows a typical good institutional layout. The soiled work is received in a room near, but definitely separated from the clean linen room. The flow of work provides for the shortest flow of the heaviest work, namely the flatwork. The flatwork winds up at the clean linen room ready for distribution throughout the institution.

When buying machinery and before installing it, it is important to obtain from the manufacturers complete instructions for installation and maintenance of that machinery. Some laundry machinery is heavy and requires substantial foundations. Recommendations about foundations and other installation features are available from the manufacturers of the machinery. Much laundry machinery is best installed under the supervision of a service man from the manufacturer. Arrangements for this



**A Typical Good Layout
for an Institutional Laundry Department**

supervision can be made at the time the machinery is purchased.

Power Services

The best laundry machinery available can be expected to give maximum performance only when provided with the power services that permit this. Included among power services must be considered water (soft and hot), clean dry compressed air at a constant pressure, steam at a constant pressure of not less than 100 p.s.i.g.* at the point of use and as dry saturated steam. The subject of power services includes a study of electrical wiring and fusing to permit constant voltages with safety at all times.

Soft water is important in the washing of clothes. It is important from the standpoint of accumulative effect of several launderings on the appearance of the linens. It is important in keeping down the cost of alkali, and soap or other detergents. There should never be permitted any failures in the water softener equipment that will allow for occasional "slugs" of hard water.

Hot water should be available to the extent of three gallons of 180° water for every pound of clothes laundered. The actual amount of water both hot and cold can vary considerably with the formulas used and the types of clothes being washed. Provision to constantly deliver this amount of water and temperature permits changes in formulas from time to time with assurance that there will be an adequate supply for consistent work.

An increasing amount of laundry machinery is being operated by compressed air. This air is most commonly used at a pressure of 70 p.s.i.g. at the equipment. Clean dry air assures regular operations of air equipment with a minimum of down time for repairs and expense of replacing valve discs and diaphragms. A method of assuring clean, dry air is by the use of an after-cooler between the compressor and the air storage tank.

Virtually all laundry drying and ironing machinery is designed to be operated at steam pressures of 100 p.s.i.g. or 125 p.s.i.g. That's the pressure necessary to permit the equip-

ment to function at its best. Yet one common laundry problem in hospitals and institutions is failure to maintain this steam pressure. Engineers not familiar with laundry equipment will frequently point out that there is more latent heat per pound steam as the pressure is reduced. They fail to recognize that the weight of steam in pounds per cubic foot decreases rapidly as the pressure is reduced. One cubic foot of steam at 100 p.s.i.g. contains about 226 B.T.U.* At 50 p.s.i.g. a cubic foot of steam in an ironer chest contains only 137 B.T.U.

Fluctuations in steam pressures result in slowing down operations to the drying time of the lowest steam pressure encountered. Therefore, a constant pressure must be provided to permit a constant pace for maximum output and minimum costs.

Piping

When good equipment fails to perform its best in an institutional laundry, one very common cause of failure is the lack of proper and adequate piping to that equipment. The matter of specifying piping can most reliably be obtained from persons or organizations who have a background of experience with the laundry plant. These include prominent laundry machinery manufacturers, a few consultants and the American Institute of Laundering. There is a strong tendency on the part of engineers not familiar with laundry operations to underestimate the piping requirements. Commonly, the load requirements for water, air and steam are stated in terms of gallons, cubic feet or pounds per hour. Calculations made on that basis do not provide for the intermittent demand loads.

Good washing machines standing idle waiting to be filled with water represent an investment loss at a high cost. A rinse level in a 42" x 84" metal washing machine calls for about 125 gallons of water. If this is to be all hot water, provision should be made to admit 125 gallons of water into that one machine within 40 seconds. That is at a rate of 187½ gallons a minute. If two machines may be drawing water at the same time to a rinse level, a total is at a rate of 375 gallons per minute. If three machines are each drawing this amount of water at the

same time, it will be necessary to provide for a flow at a rate of 562½ gallons per minute to fill these machines simultaneously. With manually operated washing machines, the probability of this requirement is remote except in a very large laundry. With automatic, particularly fully automatic machines, it is very likely that three machines may be drawing water at the same time. Therefore, water piping calculations should be based on the probable maximum rate of flow per minute to permit maximum utilization of equipment, supplies and man-power.

Air lines should be large enough to avoid heating of the piping at any time. Any heating of air lines indicates excessive friction which in turn indicates that the pipe is too small for the load that it carries. This friction results in a failure to deliver adequate air at the point of use and also throws an excessive load on the compressor.

Steam piping and the piping for returns must be adequate. Experience indicates that calculations of steam piping on the basis of rated steam load per hour fails completely to provide the desired heat at the point of use.

The most practical and foolproof calculation of piping for steam is that of using the size of the fitting to the equipment as a basis for determining the pipe size required. The pipe size to that equipment should not be less than the size of the fitting, and should preferably be one size larger. To determine the size of a header to feed several pieces of equipment, calculate the total square area of all branch lines and from that determine the size of the header required. If the line is short and with a very limited number of fittings, the header should have a square area equal to the total square areas of the pipe fittings to the equipment. If, on the other hand, the steam line has a long run or a great number of fittings, use nothing less than the calculations based upon the total of the next size larger than each individual fitting.

The Laundering Process

Any hospital, whether it be for the specialized treatment of mental disorders or physical ills, is seriously concerned with the preservation of linens.

* Pounds per square inch gauged (above atmospheric pressure).

* British Thermal Units

Many thousands of dollars are invested in linens and may be wasted needlessly if the proper care is not exercised in the purchase, use and laundering of linens. Each of these factors deserves full consideration. A careful comparison of the quality of linens with respect to cost may mean a distinct savings.

The purchase of linens by the fairly new L 24 standards of the American Standards Association will insure obtaining good quality serviceable linens. It should be borne in mind, however, that L 24 is a minimum standard. Some linens that measure up to these standards might not be worth as much as those which far surpass the minimum requirements of the L 24 standards. Laboratory comparison testing will help decide which product is the better value.

Care of linens in use is an important factor. Linens should not be used for any purpose other than that for which each type was originally purchased. For example, sheets and pillow cases should not be used for laundry bags. Stains or damages or both may result from this practice. Soiled sheets or towels should not be used for wiping rags, since stains or damages often make them unusable.

Wherever possible linens should be protected from contact with outside influences. In sterilizing linens, sterilization indicators should be used in accordance with manufacturer's instructions. Some devices used improperly will produce an acid which will damage cotton fabrics. (A.I.L. Textile Note No. 32).

Some quick-setting surgical casts stain pillow cases when pillows are used to support a newly "set" break in a fresh, wet cast. Special paper covers will prevent these stains.

Specific Methods

Care in laundering is, of course, a must. Proper laundering procedures and good control over the procedures extend the service life of linens and cut linen replacement costs. Lightly soiled hospital linens that are changed daily can easily be washed with a procedure such as the following.

The amounts of supplies listed are for 350# loads and are approximate, more or less, supplies that will be needed depending on the amount of soil.

Oper.

No.	Operation	Time	Level	Temp.
1	Suds (Built soap to good suds)	5 min.	6 in.	140°F
2	Bleach (1 qt./100# load)	5 "	6 "	160°
3	Rinse	3 "	12 "	160°
4	Rinse	3 "	12 "	130°
5	Rinse	3 "	12 "	110°
6	Sour (4 oz. sour/100# load)	5 "	6 "	100°

For less frequently changed linens and white wearing apparel a procedure such as given below or an adaptation of it may be needed:

Oper.

No.	Operation	Time	Level	Temp.
1	Breaksuds (2# alkali / 1-1½# built soap) (0.75# of built soap)	7 min.	6 in.	130°F
2	Suds (5 gals. stock soap)	5 "	6 "	160°
3	Suds (0.5# of built soap)	5 "	6 "	160°
4	Bleach (7qts.-1% Bleach)	7 "	6 "	150°
5	Rinse	2 "	12 "	160°
6	Rinse	2 "	12 "	120°
7	Rinse	2 "	12 "	100°
8	Rinse	2 "	12 "	100°
9	Sour&blue (Sour to pH 5)	5 "	6 "	100°

In the case of linen and wearing apparel from incontinent patients two or three flushes at 90°F-100°F should be used before starting this second washing procedure.

The factors involved in washing which can cause weakening and premature wear if not controlled are the bleach and the mechanical action. Long running times between draining and filling, for example, leave the fabrics free to rub and scrub without the cushioning effect of the water. This may cause mechanical wear on the fabric that might be eliminated. Improperly controlled bleaching may chemically weaken the linens.

Studies of bleach requirements have indicated that family white laundry requires not more than 2 quarts of 1% available chlorine bleach per hundred pounds of soiled clothes. Linens that are less heavily soiled and stained do not need as much bleach. In fact, the use of this much bleach on lightly soiled loads may represent overbleaching.

Three precautions are to be taken for the most economical management of linens: (1) Buy good quality linens at the best price, (2) Use linens for the designated or intended purposes only, and (3), Set up recommended washing procedures and supervise their application.

Personnel

The laundry should be in the charge of an individual who knows commercial laundering procedures. He should be qualified to offer specifications for the purchase of all linens and garments and to approve the merchandise delivered to ensure that it meets the specifications. This will eliminate controversies about laundering properties of fabrics which are being considered for purchase. We feel that the person in charge of the laundry should have the sole responsibility for deciding which linens and garments are to be mended and which discarded. By recording the durability of various items, he will have useful statistics on the relative merits of the various types and specifications.

Personnel must be selected and trained to the specific jobs in the laundry. The best results are obtained by selecting a person who is physically, mentally and emotionally qualified for a specific job and then providing the training that will permit him to attain standard performance as quickly as possible.

A worker's interest in his job is stimulated when he knows at all times what the score is. The laundry manager can bring this about by posting daily or, better still, hourly records of output on bulletin boards in the laundry. Not only will this add interest in the job but also will encourage increased output. This plan calls for performance records, measurements of the work output and of the number of labor hours spent in producing it. On some jobs it can be measured by individual operators and calculated accordingly. Other jobs in the laundry, however, are of necessity group operations; here it is important to measure the daily load and calculate the output per operator hours.

Laundry operations should be re-studied periodically to obtain a critical analysis of the work load and methods in order to find an easier way of doing every job.

SAFETY PROGRAM REDUCES ACCIDENTS

By H. F. TOWNSEND, Personnel Director, Arizona State Hospital, Phoenix

IN THIS HOSPITAL, we believe that safety is an activity which must start at the top of the organization and permeate throughout every department. We believe, too, that most accidents have a human element, and if the mental attitude of the employees can be properly guided, one large accident-producing factor can be reduced.

We have therefore appointed a Safety Committee consisting of the assistant hospital director as chairman; the business manager; the personnel director; the chief engineer; the chief dietitian; the director of nursing and the supervisor of general services. The goal of this committee is stated in its appointing letter, as follows:

"The purpose of the Hospital Safety Committee is to help in the prevention of injury and occupational disease to persons, and damage to property through accident, fire and explosion. Its task shall be to identify and assist in the correction of specific conditions and work practices which may cause injury or which may create conditions favorable to fire. It shall also teach employees and patient helpers how to work without injury to themselves or others, thereby increasing the efficiency of the hospital."

The Committee meets as often as possible, and at least every sixty days. It is concerned with accident rates, trends, prevention awareness; it obtains facts, makes recommendations, develops safety programs and reviews corrective action.

Careful Reports Kept

The facts used by the committee are obtained from patient and employee reports. To summarize this information the Committee developed an "Accidents Statistics" form, applicable to both patients and employees. This report is rendered to the Committee monthly; it gives the number of accidents, the persons in-

involved; the department or ward; the date, time and place; nature of the injury; the agency and agency part; the unsafe condition; the accident type and the unsafe act. These reports are kept separately on patients and employees, and are classified in accordance with suggestions from the Branch of Industrial Hazards, Bureau of Labor Statistics, U. S. Department of Labor.

From these reports, the following classification of accidents has been developed which the Committee finds quite satisfactory: Striking against objects; struck by objects; caught in or between objects; fall on the same level; fall on a different level; slip (not fall) or over-exertion; contact with temperature extremes; inhalation, absorption or ingestion; contact with electric current; miscellaneous.

More Accidents in Summer

During the first ten months that safety records were kept, the Committee found that the numerically largest number of accidents to patients and employees was caused by being struck by objects, followed fairly closely by falls on the same level (on the part of patients) and slips or over-exertion (on the part of employees.) There were more than four times as many accidents to patients as to employees. According to the figures from this one southwest hospital, it appears that mean temperatures affect accident rates. Both patient and employee accident reports in July, August and September were appreciably higher than in other three month periods.

The accident rate of employees in our hospital is high in comparison with other hospitals in the United States, according to statistics published by the National Safety Council. Since, however, there is no breakdown as to the type of hospital in these statistics, and since there are more accident-causing factors in a mental than in

a general hospital, we cannot be sure that these statistics give a valid comparison.

In addition to these tabulations, patient accidents are tabulated by wards. By inspecting this tabulation and the employee accident reports the committee is able to determine hazards in particular areas and to note any correlation between patient and employee accidents in these areas. The high correlation, both as to type of accident and monthly rates between patient and employee rates has strengthened the Committee's belief that if employee accidents can be reduced, the accident rate of patients will also decline.

Accordingly, the Safety Education Program is a portion of the in-service basic training programs of all employees. In addition to the training program, the hospital monthly newspaper carries a "Safety Box Score" which reports the number of accidents and suggests preventive measures; safety posters are posted conspicuously throughout the hospital; the quarterly results of the Hospital Safety Contest conducted by the American Hospital Association and the National Safety Council are posted for the information of all employees; supervisors are required to report in writing every accident, however trivial; accident prevention information is circulated by word of mouth.

Program's Effectiveness Seen

The administrative staff believes that the safety program has reduced accidents. Evidence includes the number of requests which the engineering services receive to reduce physical hazards; the interest demonstrated by supervisors; the belief of all employees that good safety practices have led to better working conditions; and also the fact that obviously unsafe practices are less often observed.

The Industrial Insurance of the hospital is carried in a blanket insurance policy which covers other state employees; because of this, the Committee has been unable to obtain accurate information as to the costs of insurance to the hospital; it is true that the rates on this policy have dropped steadily until the last six months, but there is no way to determine how the safety program at this hospital has affected insurance rates.

A Housekeeper Shares Her Experiences

An orientation plan, some labor saving tips and a safety idea which will interest all housekeepers

By HELEN K. JOHNSON,
Executive Housekeeper,
The Menninger Fndn., Topeka, Kans.

BLUE LINE PRINTS (made in a reduced scale from blue-prints) of the hospital building, mounted under clear plastic on cardboard, have proved excellent for showing job areas to new housekeeping employees. Different areas are colored in with different colored wax pencils—room numbers and room divisions on the blue line prints show through the lightly waxed plastic. If job areas change from time to time, because of work loads in various areas, the colored wax wipes off easily and the extended job area can be shaded in the correct color.

The bête noire of many a housekeeping employee is the black mark left by rubber composition heels and soles of shoes! Our damp mopping supplies include a steel wool pad (size 00). On hard surfaced floors, this pad under the damp mop easily removes the black marks. No squatting, no stooping, no hard work—cleaner floors—and much more cheerful employees!

Dust cloths, sprayed with "Nu-Treat" (Costello Manufacturing Co.) are not only good non-oily cloths for dusting furniture, but are also excellent for cleaning and polishing chrome fixtures. A daily wiping with a Nu-Treated cloth makes scouring and wiping dry the chrome plumbing fixtures a thing of the past.

The addition of 2 oz. of cleaning alcohol to each gallon of soapy water (about 8 oz. of powdered soap containing no wetting agent) speeds up the drying time for carpets shampooed while tacked down. The alcohol prevents the back of the rug from getting too wet, thus reducing shrinkage; the area can be put back into service faster. Static electricity is noticeably reduced in our carpeted hallways after a good shampoo.

Flameproofing draperies is the last step in our laundering process. With the addition of a Maytag washing machine to our laundry equipment,

we can thoroughly saturate the drapery fabric with a flameproofing solution by a few turns of the agitator. We loosely wring the solution back into the machine for re-use, and add chemicals in proportion to keep the solution adequate.

The formula we use is 7 lbs. borax; 3 lbs. boric acid; 1 oz. wetting agent to 10 gallons of water. With this formula, no starch is needed. The treated draperies should have increased 8 to

10% in weight after the fabric is treated and dried (as compared with their original weight) in order to be effectively flameproof.

An almost indestructible mattress cover can be made by machine quilting together (in one inch squares) two pieces of closely woven monks cloth. It is washable, soft and pliable and easy to store when not in use. The material should be preshrunk before quilting.



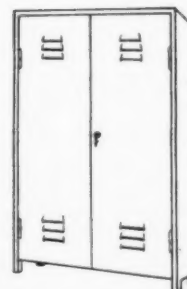
"IT'S A REVELATION to behold the improvement in behavior of our patients since we've been using merchandise from Karoll's. Treatment and care are simplified. We have time to do a better job. And we're saving money."

ELGIN SYKO WARD-O CHEST-O-BED

*The space-saving bed ensemble
with THERAPEUTIC
benefits!*

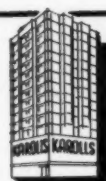


WARD-O-BED is also available in two-door back-opening models.



"This is it!" That's the unanimous reaction of all hospital officials who have seen the WARD-O-BED. The headboard wardrobe is security type, spring bolted to corner—same as the chest. Height, 45" or 60", (including 4" feet with glides); width 36"; depth, 7 1/8". Both side and back-opening doors lock with chest key. An ensemble that's perfectly practical and practically perfect for all institutional use. Wire or write now for further details.

KAROLL'S, INC.
INSTITUTION DIVISION
32 North State Street
Chicago 2, Illinois



Canadian Distributors

SIMPSON'S

45 Richmond Street, West
Toronto, 1, Canada

DEPARTMENTS

New Uses For Old Plastic Mattress Covers

Metropolitan State Hospital, at Norwalk, Calif., uses plastic covers over innerspring mattresses and in normal usage, the covers become damaged and are not usable for the purpose originally intended. There are, however, large portions of the plastic material available for use and these are trimmed out and made into adding machine and typewriter covers, waterproof aprons for the scullery, dairy, the paint shop and similar areas.

The latest idea was to make a bib for those bedridden patients who are a feeding problem. Bibs are rather large, about 18" x 30" with a 6" pocket running fully across the bottom of the bib. Soups, gravies and drinks are bound to be spilled as the patients eat; the bib catches this spillage and a goodly portion of it runs down the bib and into the pocket. This provides an appreciable saving in time, the laundry of bed linen, and bed clothing of the patient. The bib itself is very readily rinsed off and hung out to dry for the next meal.

L. C. WAYNE,
Asst. Supt., Business Services

All Employees Share Task Of Preventive Maintenance

At the Richmond State Hospital, Indiana, a system of small printed forms, 4 1/4" x 5", known as "Repair Tickets" has been instituted. A pad of these printed forms, interleaved with carbon paper so that they can be prepared in triplicate, has been placed at strategic points throughout the hospital. Any employee who notices an actual or potential disrepair anywhere in the hospital area is urged to submit a repair ticket in triplicate. The tickets are printed in such a way that the employee need only put check marks beside the proper words to show the location and type of repair needed, and the specific repair man for the job—i.e., carpenter, plumber, painter, electrician, etc.

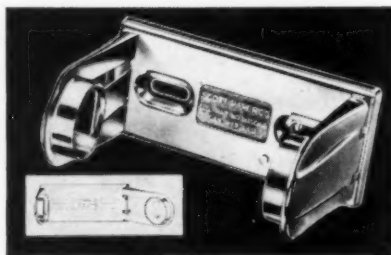
The reporting employee signs and

dates the three copies and sends them to the Business Office. The office clerk stamps each set with a code number, sends the first copy back to the originator. As soon as possible, the Maintenance Engineer sends the proper repair man to correct the faulty condition. When the repairs are satisfactorily completed, the reporting employee signs the completion date on the third copy of the ticket and sends it back to the office. The repair man put the completion date on his ticket and returns it to the Maintenance Engineer.

Pending repair tickets are filed by the Maintenance Engineer numerically according to the code number. If a job has not been satisfactorily completed within a reasonable time, a glance at the files and a phone call will speed up the repair work.

EVELYN AMMON,
Inventory Clerk

Toilet Fixture Offers Safety and Savings



For the past five years we have been successfully using a toilet paper fixture manufactured by Scott Paper Company—their #964 fixture. Once a roll of paper has been inserted it cannot be removed except by an attendant with a special key (supplied free of charge.) It has no loose parts which can become lost or be used as weapons. It is sturdily constructed and neat in appearance. The spring can be so adjusted (by the attendant only) that as much or as little paper may be fed as is desired—thus eliminating the problem of the patient who enjoys feeding toilet paper into the bowl to the dismay of plumbers!

ALEXIS TARUMIANZ,
Business Administrator,
Delaware State Hospital, Farnhurst.

Turbidity Testing Effects Linen and Laundry Economies

The use of a turbidimeter, an electronic machine designed to test the turbidity of water samples, has saved the Stockton State Hospital, California, several thousand dollars, by increasing the load handled in the laundry and reducing fabric wear.

In the washing process, chemicals are effective cleaning agents up to a certain point, but when the chemical cleaning action ceases, it is not desirable to continue the operation. Continuation tends to produce unnecessary wear on fabrics because of excessive mechanical action, and it is actually possible to redeposit soil in the fabric by continuing the washing operation beyond the period of its usefulness.

By testing the turbidity of the water, the peak of cleaning effectiveness can be determined by recording the moment when the greatest amount of soil is held in suspension in the wash water. Operation time beyond this point is wasted and can be trimmed from the washing cycle.

During the testing period, water samples from the wash wheel were given a turbidity test at one-minute intervals throughout the cycle. After the peak soil removal time was determined for each phase of the cycle, a new control plate was cut in accordance with the findings. After these revised automatic control plates were put into use, a follow-up program confirmed the accuracy of the original tests.

Water samples used for turbidity tests were passed through a fine screen to determine the degree of "felting," an evidence of fabric wear. The reduced running time reduced the amount of felting. The appearance of the linens is improved and we estimate that the tensile strength loss has been reduced from 20% to 25%.

Turbidity testing alone will not achieve the highest possible production, but it has enabled us to cut valuable minutes from every washing cycle—in some cases as much as twenty minutes.

HARRY A. LEWIS
Hospital Industries Supervisor

Plastic-Coated Ticking Preserves Mattresses, Saves Money

An extra \$2.64 each spent on the manufacture of mattresses in our own shops actually saves us about \$5,000 a year, at the Saskatchewan Hospital, Weyburn. The \$2.64 is the difference between the cost of regular mattresses made in our shop, at \$5.07 each, and the ones we make now, which are covered in plastic-coated ticking, and cost \$7.71 each. The savings result from the fact that whereas we used to replace about a thousand mattresses and a thousand rubber sheets a year, the replacement figure for mattresses is now about one hundred, and for rubber sheets, less than forty a year.

We have about four hundred of the plasticized mattresses in use in all wards where soiling, wetting and destruction may occur. (Our hospital has quite a number of low grade mental defectives and senile patients whose bed habits are untidy.) Before we started using the plastic-coated mattresses for these patients, about 150 soiled mattresses were returned to the shop each week, and twenty of these would have to be replaced. Now only fifteen or twenty mattresses go back to the shop weekly, and only about two have to be replaced.

The plasticized ticking wipes clean with a damp cloth and is extremely durable. It can be boiled, washed with numerous detergents, heat sterilized, soaked in urine and still remain entirely waterproof. Pieces left over from mattress making are used for cushions for incontinent patients, sick ward and operating theater pillows and for aprons for the operating theater staff and others.

Apart from the economy factor, the new mattresses have other advantages. They do not hold the smell of urine or feces after washing; they dry quickly and can be put back in use. Much time is saved in the laundry which formerly had to wash at least 150 a week. Not only is there no increase in bed sores—the bane of incontinent patients—but there have been no bedsores at all on the male wards where these new mattresses have been used.

The Upholstery Shop, which used to stink mightily due to the mattress fillings, is now clean and sweet. Freed

from the endless task of mattress filling and making, the staff of the shop can devote itself to maintaining hospital furniture in good condition, and teaching patient helpers the useful and enjoyable craft of upholstery. (Our hospital is the brighter for excellent, cheerful looking upholstered furniture—a further by-product of this simple innovation.)

Much credit must be given to Mr. Salwach, one of our supervisors who emphasized the need for some sort of waterproof mattress, and who noticed

an article in *MENTAL HOSPITALS* (May 1953, p. 6), describing a method in use at the Vermont State Hospital. It took us several months to develop our present method, during which time we had the assistance and technical advice of Messrs. George N. Jackson, Ltd., of Winnipeg, the representatives of the Monsanto Chemical Company, of Springfield, Mass. and Oakville, Ontario.

HUMPHRY OSMOND, M.D.
Superintendent
The Saskatchewan Hospital

Central Vegetable Preparation Saves Time, Money and Labor

The establishment of a Central Vegetable Preparation Unit at Topeka, Kansas, State Hospital has resulted in improved menus, and economy in labor. This unit is supervised by the chief cook, Mr. Edward Juneau.

The advantages of this central preparation area are the economical use of equipment, labor, time and fresh products. The garden and farm produce is better utilized. Food control and uniformity of the fresh products is effected.

Certain pitfalls must be avoided. Fresh food must not be prepared so far in advance that nutritional content is lessened. Without proper refrigeration, fresh foods can become dehydrated. Good delivery service, proper containers and well-trained employees are essential to the success of such a plan.

Not all kitchens are equipped to prepare all fresh items. Thus a central preparation department makes it possible to use the same menu for the whole hospital, and to have proper portion control. Purchase is simplified because the "as purchased product" in relation to the "edible portion product" can readily be determined from past experience. Waste is controlled by the use of special equipment and experienced operators. Before the central unit was put into operation, each of the four kitchens frequently had small amounts of fresh vegetables left over, but not enough to use in another meal. The extra vegetables were put aside, and frequently spoiled before they could be used.

Time and labor are saved because there is no need for duplication of work in the four different kitchens.



Our operation time has been reduced by one-half. Fewer employees need to be trained in the operation and care of the equipment and less equipment is needed for the one area.

The preparation area helps keep the kitchens more sanitary because all the dirt and insects from the crates and raw foodstuffs are disposed of before the vegetables reach the kitchens. The cleaning is confined to one area and can be taken care of in a sanitary manner, by means of large garbage disposers for peelers and trimming. This eliminates transporting the waste to and from several kitchens.

As to portion control, the dietitian is assured that each kitchen receives enough prepared food for a two, three or four ounce serving as planned. Before the unit was opened the cooks would sometimes run short of time to prepare the raw foodstuffs, with the result that a much smaller serving was given than planned. Portion control was impossible.

RUTH DUREE,
Chief Dietitian

Successful Supervision Discussed by Conference

The supervisor of the mid-twentieth century is a leader, not a driver, emphasized Professor Richard Bourne of the Faculty of the University of Nebraska, who was one of the leaders of a two-day conference of supervisory personnel in mental hospitals, recently held at the Nebraska Psychiatric Institute.

The conference was conducted as part of the Institute's Interstate Training program which is supported by a grant from the National Institute of Mental Health. The key speaker was Dr. Lee G. Sewall, Manager of Perry Point VA Hospital, Maryland. Other leaders were Professor Bourne and Professors Niles Barnard, William Dick and L. Ross Garner, all from the Faculty of the University of Nebraska. One hundred and forty-three mental hospital people from four states registered for the two-day meeting. They included nurses, charge aides and ward managers, food service workers, accountants, housekeepers, business managers, laundry workers and others.

The conference was concerned with discovering what makes a supervisor succeed or fail. All speakers emphasized the importance of good relationships between supervisors and workers. Failure of supervisors was seldom for technical reasons, but because of their inability to relate to the work group in the proper way.

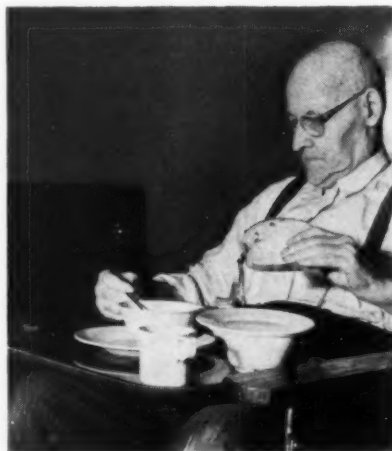
Among the personal qualities needed by a good supervisor are intelligence and acceptance by employees because of his own honesty, fairness and good judgment. He must readily accept responsibility and must delegate authority without imposing on his subordinates. He must have high moral standards and be orderly in himself and his personal life; his social attitudes will be positive and he will converse easily with all kinds of people. He has a healthy respect for necessary records and reports. He must be able to plan and organize work; give direction to activities; control the quality of the work by setting standards; coordinate the activities of his department with those of others.

Historically, said Professor Bourne, the boss was autocratic and authori-

tarian, using position and power to manage his workers. Today, however, direction is permissive. Workers are expected to participate in decisions and group feeling is encouraged and utilized. Authority is used only as a last resort.

In a discussion of the community and the mental hospital, Dr. Sewall urged supervisors to develop informed and healthy attitudes among employees by proper orientation to the hospital and mental health. He urged that hospital resources should be shared with the community and that hospital staff should participate in the development of community mental health programs. Acclaiming the current changes from custodial to therapeutic care, Dr. Sewall said that since environment is of the utmost importance to the patients' well-being, hospital supervisors should develop a "personality" for their institution as a framework for the therapeutic program.

Seniles Feed Themselves in Comfort



The above device, developed by Mr. A. Dauphinais, a nurse at The Saskatchewan Hospital, Weyburn, enables elderly, confused patients to feed themselves instead of having to be spooned. A longer wooden arm-rest, measuring 28" x 3 1/2" and 7/8" thick, was fitted to the wheelchairs. The arm-rest is grooved on the inside so that a standard-sized cafeteria tray can be inserted firmly into the groove. The trays do not upset and the food is readily accessible to the patient. Spilled particles remain on the tray, saving the patient embarrassment. Manufacturers of wheelchairs might well adopt this type of arm-rest in future designs.

Continuous Education of all Personnel Reduces Fire Hazards

Fire protection in any mental hospital includes employee education in fire protection measures, and monthly inspection and correction of fire hazards.

The fire chief at Topeka, Kansas, State Hospital explains hospital procedures in case of fire to each group of new employees. A day or two afterwards he goes on the ward to teach each new ward employee how to use the extinguishers there. A few days later he returns to review the instructions with the new employee.

Approximately every two weeks a fire drill is held somewhere on the hospital grounds, to keep each person alert to fire hazards and aware of his duties in case of fire. After the drill, the person in charge of the building which supposedly caught fire sends a report to the superintendent, listing numbers of ambulatory and non-ambulatory patients evacuated, time required for evacuation, number of aides on duty and special problems encountered. Based on this experience, plans are then made to improve evacuation procedures. Later drills reveal whether the problems were corrected.

The fire chief inspects buildings and equipment each month, and sends the superintendent a written report of existing conditions.

One of the problems uncovered was that two-inch fire hose was too unwieldy for female nurses and aides. It has been replaced with 1 1/2-inch rubber lined hose, with fog nozzles. It has a National standard thread which matches that on hose used by the city fire department.

Soda-acid hand extinguishers are being replaced with 2 1/2-gallon water hand pump extinguishers. With these, the flow of water may be stopped at any time and started again at will. If a bed or trash fire thought to have been extinguished breaks out again, the same water hand pump may be re-used immediately. Once a chemical extinguisher is turned over, it runs itself out without stopping and must be refilled before it can be re-used.

DEAN WAY,
Fire Chief

We
hangin
Found
they
pound
this p
rity r
may b
Join c
stalle
can b
constr
are m
23rd S
The
which
the t
that c
arate
a slip
other
to the
draped
then
from
Sin
or iron
the d
to pro

Hos

At
a syst
hosier
socks.
in pl
Th
prepa
iery,
dry y
net. L

Th
close
stamp
The
tered
iery"
show

Th
the
build
which
are s
made

Safety Device for Hanging Draperies

We have developed a method for hanging draperies at the Menninger Foundation, Topeka, Kansas, so that they will come down if just a few pounds of weight are placed on them; this permits them to be placed in security rooms without danger that they may be used as a noose. We use Jiffy-Join drapery channels that can be installed on wall or ceiling surface or can be imbedded in plaster during construction. The channels and tapes are made by Jiffy-Join, Inc., 153 West 23rd St. New York, 11.

The linen tape, which has tabs in which the metal beads that slide onto the track are imbedded, was cut so that each metal bead became a separate tab. Onto this tab one-half of a slip cover snap was sewed, and the other half of the snap was then sewed to the drapery where ordinarily a drapery pin is inserted. The drapery then snaps onto the tabs that hang from the Jiffy-Join track.

Since there are no hooks to remove or iron around, it is easy to take down the drapes for cleaning, and it is easier to press them.

MILDRED LAW
Associate Secretary

Hosiery Washing Procedure

At the Philadelphia State Hospital, a system has been set up which cuts hosiery losses to the minimum. All socks, stockings and anklets are washed in plain laundry nets.

The ward personnel responsible for preparing the laundry nets the hosiery, and not more than ten pounds dry weight of hosiery is put in one net. No net is more than one half full.

The net bags are then securely closed with a net pin on which is stamped the building designation. The number of hosiery bags is entered on the laundry list under "hosiery". No individual hosiery count is shown.

The hosiery is washed and dried in the net bags and returned to the building without being opened. Bags which do not comply with the rules are sent back unwashed and a report made to the nursing office.

HELEN M. EDGAR, R. N.,
Director of Nursing

Vacuum Food Containers Serve Several Purposes

During the past three years, we have been using "Aervoid" Vacuum Food Containers in our Dietary Department, and find them extremely satisfactory for transporting food a considerable distance from the main kitchen to the wards. We use the special preheater and sterilizer, which are easy to keep clean. The maintenance cost on the containers has been practically nil.

A great advantage is being able to fill them before serving time without loss of flavor or heat. The beverage containers are especially useful for off-duty parties in the wards or elsewhere. Because of the wide variety of sizes and arrangements of the inner pans, the containers meet the needs of many different-sized wards.

N. ADELAIDE DODDS, B.H.Sc.,
Dietitian, Saskatchewan Hospital,
North Battleford, Sask.

Committee Introduces Practical Safety Measures

Mental hospitals have peculiar hazards not necessarily found in general hospitals. Studies of safety measures and education in general hospitals, therefore, while applicable in a general way, do not meet the entire problem of safety in mental hospitals.

Because of this the Saskatchewan Hospital, Weyburn, set up a Safety Committee consisting of representatives from all divisions of the hospital, but with the largest representation from the nursing services. The aim of this Committee is to bring in recommendations on all matters related to the safety of patients and staff.

The hospital newspaper carries information about the activities of the committee, and through the courtesy of the Division of Health Education, safety pamphlets and circulars were obtained and distributed to the staff. On the blanks provided the staff members listed hazards of which they were aware.

Some of the results of the Committee's work have been:

A study of patient elopements; causes and means of prevention.

Discussions with the Royal Mounted Police on elopement information and search techniques.

Setting up a hospital safety emergency kit.

Eliminating traffic hazards on hospital grounds.

More emergency stretchers made available where needed.

Election of a hospital member to the City Safety Committee.

The removal of several fire hazards in the hospital.

Special safety measures introduced in geriatric units.

The installation of emergency safety lighting.

The institution of Civil Defense measures in the hospital.

M. M. FLADAGER, R.P.N.,
Deputy Supt. of Nursing

Rotating Menu Items Add to Patients' Food Enjoyment

All of us have aversions to certain foods, and idiosyncrasies with regard to the preparation and serving of others. Such aversions are often exaggerated in psychiatric patients.

Yet the activities of the dietary department and even menus must be routine to a certain extent, because of the number of meals served daily. But at Stockton State Hospital, California, we have introduced certain innovations which have given the patients a great deal of pleasure.

We have divided the hospital patients in four groups of about 1,200 patients. We did this because the special items we wished to serve could not be served properly to forty-eight hundred patients at one time. Each week, we serve some of the following items to each group: steak; lamb chops; pork chops; cream pies; filled doughnuts. Each morning one group receives hot cakes with syrup or jelly; as soon as this treat has been received by all, we alternate with french toast, syrup and jelly. Each dining room receives a weekly menu which is posted on bulletin boards near the cafeteria line.

A few pessimists said that this system would never work; the hot cakes would reach the dining rooms soggy and cold; the steaks would be tough and cold; but because of cooperation on the part of all dietary personnel, the results have proved very satisfactory.

MRS. LOU WHITNEY,
Food Administrator II

Dishwasher Cleans Equipment Other Than Dishes

Grease filters over ranges and ovens, if carefully constructed to go into the automatic dishwasher, can easily be cleaned by the machine without all the mess of cleaning with a steam hose. The machine should be over-charged with any good washing compound. Air-conditioner and other filters can be cleaned in the same manner.

It is best to do these heavy cleaning jobs immediately before the dishwashing machine itself is scheduled for a cleaning and overhaul.

IVAN FRYE, Chief, Dietary Dept.
The Menninger Foundation,
Topeka, Kansas

Cost Accounting For Minor Construction

Apart from major construction—the erection of entirely new buildings and facilities which is usually done on a contractual basis—every mental hospital faces an almost continual problem of alterations and improvements, some of them extremely costly. While space does not permit a detailed analysis of the many intricate problems of cost accounting for so-called minor construction projects, a general discussion of the steps necessary to set up a system of cost accounts covering such work may be helpful.

The purpose of such cost accounts is to permit the value of a particular addition or improvement to be set up in the records of the institution as an increase in plant investment, as distinguished from purely maintenance work or repairs. Should a particular appropriation cover several items of "minor construction" a separate cost account or ledger sheet should be set up for each item or project. Each individual account will show the amount appropriated for the purpose, the amount expended and the unexpended balance.

Separate cost accounts should be set up for labor and materials under each project heading; time cards should be used, showing the date, project number, title of project, employee's name, rate of pay and number of hours worked on each project. A man might work on several projects during each pay period, yet the labor charges must be recorded against the

proper project. These time cards should be made up by the employee or timekeeper, signed by the foreman or supervisor of each project and forwarded daily to the accounting department for recording.

Documents requesting the purchase of materials should also indicate to which project the material should be charged. Materials returned to credit should be recorded as quickly as possible, and the payment of invoices kept on a current basis in order to reflect correct costs.

One important purpose of such a cost system is to keep the management, as well as the engineer or superintendent in charge, informed on up-to-the-minute costs on each project. This can be done periodically by rendering a report to those interested, showing the cost of labor to date on each project, as well as the cost of materials purchased and the balance of funds available for use. This report should also indicate charges for accumulated vacations, retirement, if applicable, or any other item which is properly chargeable to the project.

OTIS K. REIFSNYDER, Accounting Officer,
DeWitt State Hospital, Auburn, Calif.

Electric Tow Truck Avoids Outside Linen Delivery

Pontiac (Mich.) State Hospital has adopted a new method of linen delivery and pick-up. Using a Lewis-Shepard electric tow truck and twenty Nutting four-wheel leader trucks, outside linen delivery and soiled linen pick-up has been eliminated for all but the Cottage Buildings.

Clean linen is packed in baskets, marked for ward delivery and sent to the laundry basement by linen chute where it is sorted by delivery area and loaded on leader trucks. After the leader trucks have been assembled into trains they are towed through the basement tunnels by the electric truck to the basement delivery areas. At the delivery areas they are unloaded for delivery to the wards by service elevators. On the return trip soiled linen is transported back to the laundry basement where it is moved by elevator to the soiled linen sorting room. This single electric truck has been hauling weekly linen loads in excess of 120,000 pounds.

This new delivery method has not only released a motor truck for other

hospital work and eliminated the problems of outside delivery in inclement weather, but has evened the flow of soiled linen going to the laundry.

GERALD A. BAX
Business Executive

Hospital Areas Not Keyed To Master System

Certain areas of a mental hospital are usually not keyed to the Master system for obvious reasons. The warehouse, canteen, storage areas and pharmacy are ordinarily on separate keys.

Keys to these areas are usually held only by those employees directly concerned; the business manager and/or superintendent will have a duplicate key. It may occasionally be necessary for a key to the pharmacy to be available to the Clinical Director or the Officer of the Day to allow them to get into the pharmacy for emergency supplies, but the pharmacist may prefer to be called at night in case extra supplies are needed.

Locks on pipe spaces and mechanical division service rooms are usually keyed separately from other building keys. This is sometimes unfortunate because the mechanical division people do not always keep these areas very clean. Housekeeping personnel should be able to clean these areas at regular intervals.

CHARLES K. BUSH, M.D.
A.P.A. Central Inspection Board

New Type Conditioner for Hot Water Tanks

Our water conditioning problem is being solved very satisfactorily at the Menninger Foundation, Topeka, Kans., with the Packard Water Conditioner. This equipment uses a principle of nuclear physics, instead of chemicals, to eliminate scale and corrosion. An energy generator restructures the minerals contained in the water, changing them from scale-forming crystals to non-adhering mud, which is easily drained from the coils.

We are now able to maintain the temperature on our hot water tanks much better, and find this equipment much more effective than previous procedures.

HOMER JAMESON
Chief Engineer

SPECIFICATIONS - AN AID TO PURCHASING

By B. R. CHEYNEY, State Purchasing Agent

California Department of Finance, Sacramento

A PURCHASING OFFICE has as its main purpose the procurement of the best equipment, materials, and supplies of the right quality, at the right price, at the right time for the use of the company or government of which it is a part.

The Purchasing Office uses several tools to accomplish this function. One of these tools is the specification. Specifications are a three-fold tool. They enable the user to indicate what he wants in plain language which others will understand and, at the same time, assure him that nothing below that quality will be procured; second, they are a great aid to the Purchasing Agent to give him a firm basis for bidding or negotiation and so that he can accept the best offer on the specifications in a rapid, business-like manner; third, the seller or vendor knows exactly what is wanted and is frequently in a position to offer for immediate delivery an item of standard production or can, with his firm's engineering staff, design the equipment and offer a price for it with facility and sureness.

However, it should not be assumed that everything, or even the majority of items, should have a special specification. This would be a waste of time and money, and in many cases duplicate the work done by others. Groups which produce standards include technical associations such as the Society of American Engineers; American Gas Association; American Society for Testing Materials; and trade associations such as National Electrical Manufacturers Association. In addition to the acknowledged standards and specifications of a technical nature produced by these groups, there are other "standards and specifications" which are in a sense quality control specifications. These are items such as IBM machines, Coca-Cola, Sanforized textiles, etc. In some com-

modity groups trade descriptions have become recognized as having the standing of formal standard specifications. Commodities covered by this type of description are pipes, valves, lumber, etc.

Specifying Brand Names

In developing specifications thought should be given to the use of a proprietary brand name. In many instances this will serve the intended purpose not only adequately but perfectly. Proprietary brands have several advantages. They are well known, they have acceptability in the trade as standards of performance and illustrate to everyone what is wanted.

The use of a proprietary brand name as a specification in bidding or negotiating for prices does not, in itself, preclude acceptance of offers of other brands. Whether to accept other brands, of course, is only a question when intermembering is not a factor, or when the item is not required for educational or rehabilitation programs where specific uses or needs may arise. When using brand names or proprietary names, "or equal" should be added to avoid the accusation of being restrictive when bidding is required. This presumes that the ordering agency is in agreement with the Purchasing Agent that an equal will be satisfactory. When an equal will not be satisfactory either for the above reasons or for others equally justifiable, then it is incumbent upon the user to state that "Toastermaster" for instance, is the only item that will be satisfactory and further to state why it is the only one acceptable. This statement enables the Purchasing Agent to proceed with the purchase of the materials without undue delay, correspondence and inconvenience to the using agency. For example, in the State College system, engineering lab-

oratories are set up wherein each of the principles of hydraulics is physically demonstrated. A specific pump or instrument is required for each principle and no other will suffice.

Good purchasing procedure indicates close cooperation between the Purchasing Department and the requisitioning department in writing a specification that will provide an acceptable product, as well as permit full and free competition among the bidders. A specification that is too detailed, however, may backfire. To illustrate, a specification was written covering a pump. It detailed the construction to the Nth degree. The successful bidder supplied the equipment just exactly as detailed. When placed in operation, the pump failed. When the supplier was contacted, he indicated that he had fulfilled his contract, and the failure was not his responsibility. He was right. This situation could have been avoided by indicating that the need was for "a pump to deliver so many gallons per minute, with a lift of so many feet against the head in feet or pressure, etc.," indicating the conditions, the liquid to be handled, etc., and including all pertinent information necessary for the supplier either to design a special pump, or furnish a standard unit. Thus a performance guarantee could be required. In such a case the responsibility is clearly the supplier's, and the purchaser is adequately protected. To order an X-ray machine the purchaser would set out the intended use of the equipment, space available, whether personnel must be trained by successful bidder, require factory service be available within 24 hours, etc., in case of machine failure, installation, wiring or furnishing wiring diagram for other electricians, etc. Also, he would state that equipment is to be guaranteed by the successful bidder to perform specified functions,

by the requirement of a performance bond in the amount of 50%, 75% or 100% of the purchase price.

These specifications at first might appear too loose and would permit every manufacturer from General Electric and Westinghouse to Joe Doakes to bid on this equipment. Frankly, that's not the concern. What is concerned here is whether the bidder will guarantee his equipment, in writing with a posted bond, to do what is specified. This specification with the guarantee provisions applied is, in fact, more strict than a detailed technical one and will almost always prevent an omission of some important technical detail as these are left to the supplier to determine, if required.

Performance Spec Protects User

The main advantage of the performance specification is that you and I (the users) are almost always assured of receiving the latest advances in the design and equipment. We receive these whether or not we were aware of their existence at the time that we prepared the specification. If we were not aware of them and wrote a technical specification for the standard item, it would rule out the use of the newer, more advanced design and equipment.

Regardless of the type of specification decided upon for any one item, specifications should be used in conjunction with standardization. That is like saying, "Which came first, the chicken or the egg?", for as specifications are developed, standardization will follow. This sequence frequently is reversed, the specification following the standardization of the item. For example, let's assume you decide to write a specification for the beds in your institution. When completed to everyone's satisfaction, you would have in fact standardized the type of beds to be used in the institution.

The food purchased in your hospital is another good example. Canned foods are almost all graded A through C by the U. S. D. A. (A choice, B extra standard, C standard). The dietitian will normally decide which grade to buy for a particular use. For salads and plain fruit dishes the A and B grades might serve best

due to their appearance, shape, uniformity in size and color, but for pies and cobblers, C grade or Standard could be excellent. The quality is good, and the factors of appearance mentioned above are immaterial for this purpose. So standardization begins. Where is the specification? It appears when the dietitian requests: six cases cling peaches, halves, Grade A, heavy syrup, 24/303's. Thus you have the specification which is based upon the standardization program.

Let Purchasing Handle Procurement

There is sometimes a tendency to call in a manufacturer's representative for "assistance" in writing a specification for a thing or product, without consulting the Purchasing Department. This is usually done in good faith with the objective of being helpful and to "expedite" the acquisition. Often it produces the opposite result and creates headaches and problems for the Purchasing Department. It should be remembered that the representative may not be altogether altruistic or objective in furnishing a specification. To be a good salesman, he must attempt to further the interests of the organization he represents, legitimately, to be sure, but try as he will to maintain objectivity, he can seldom put himself or his product completely out of consideration. You can't blame him for that—he is doing what comes naturally. Many times the use of such a specification brings unpleasant developments such as claims of favoritism, restrictive specifications, a "cooked-up deal", etc. How much simpler to call in the Purchasing Department initially, state the problem to them and let them take over. They can and should be more than willing to help. The time spent at the outset is more than offset by the time saved when they issue bids, make the award and write the order.

Management has a right to look to Purchasing for advice and counsel in all procurement problems. It's logical, and it relieves others so they may devote their entire efforts to the purpose for which they are engaged. The Purchasing people have a responsibility to perform in this field. They must be cooperative, objective, and maintain good communications and good relations with management, staff and their suppliers.

ABOUT TWO YEARS AGO, we decided to change our system of Stores Accounting from manually posted records to machine accounting. Several factors influenced this decision: (1) We already had an IBM installation at our institution; (2) We wanted to establish and maintain a better system of inventory control; (3) We needed a system which would give us more accurate costs; and (4) We felt that, because of its flexibility, more different and useful types of reports could be developed from the IBM system.

We enlisted the services of the local IBM office to make a survey to determine what kind of information was needed to develop the accounting and statistical reports desired. This information formed the basis of the new control system.

Our storeroom inventories were divided into two broad groups: (1) food and (2) supplies, including clothing. Commodity numbers (allowing for future expansion) were assigned to the items then carried in our inventories by establishing a uniform commodity description, including size and pack and the standard unit of issue desired. Stores Inventory Cards were then punched with the following descriptive information obtained from the existing inventory: Storeroom location, quantity, unit of issue, commodity description including size and pack, serial number of card, class of commodity (food, supplies, or clothing), commodity number, how acquired (purchased, donated or produced), receiving report or transfer number, value of issue unit, accounting code, requisition number and department code. Manila cards were used for one storeroom and green for the other, to avoid mistakes in identification. (Although our hospital has two units located approximately 25 miles apart, all financial and stock records are kept at the Little Rock

ACCURATE COST ACCOUNTING

By WARREN E. LESTER,

Procurement and Disbursing Officer
Arkansas State Hospital, Little Rock.

unit.) Each card storage file was arranged in both alphabetical and numerical sequence to facilitate handling of cards and for maintaining an accurate perpetual stock inventory.

The Master Card Files (used by the IBM Department) and the Set-Up Card Files (used by the Business Office) were then prepared by punching into them commodity numbers and description, including size and pack and the standard unit of issue desired. Permanent prenumbered decks of cards were prepared for us by the IBM Department to make Stores Inventory Cards in the appropriate quantities. The new system was then ready for operation.

Receiving System

Copies of all pre-numbered receiving reports are sent by each storeroom to the Business Office daily and are filed numerically in separate files for each storeroom. All unprocessed receiving reports are flagged so that a control is maintained. Another copy of each receiving report is sent to the Purchasing Department daily where it is held for checking against the invoice received from the vendor. If the information checks, it is transcribed from the invoice into the appropriate Set-Up Card, and a control tape prepared for each storeroom showing the total amount of money involved. The Set-Up Cards are then sent to the IBM Department where the Master Cards are pulled and matched for each commodity procured. The information obtained from Master and Set-Up cards for each commodity is then gang-punched into the appropriate number of blank Stores Inventory Cards. During this punching operation the cards are counted and the commodity code and serial number is printed automatically on the end of each card. When this operation is completed, the cards are then accumulated through the Accounting Ma-

chine for checking with the control tape. This tabulation then becomes a permanent record. The Stores Inventory Cards are then filed in proper commodity number sequence in the appropriate file.

Requisitioning System

The original copies of the storeroom requisitions are sent in serial number to the Business Office daily where the following cards are selected for each requisition:

- (a) Department Master Card (punched with accounting code and department number);
- (b) Requisition Card (punched with a number corresponding to the requisition number);
- (c) Appropriate number of Stores Inventory Cards for each item issued on the requisition.

At the end of the accounting period all the cards are sent to the IBM Department where the accounting code, requisition number and department number is gang-punched into cards pulled under "c". After this process is completed, the various accounting and statistical reports are developed for use and study.

Reports and Summaries

The basic accounting report is a detailed monthly listing for each storeroom by requisition showing disposition of stores. While this listing is being made on the Accounting Machine, summary cards are cut automatically on the Document Originating Machine by department number, class of commodity and type of acquisition. A tabulation by account code is then prepared, showing the debits to be made to the various departments and the credits to the appropriate storeroom inventory accounts.

The summary cards are then sorted and used to prepare a monthly sta-

tistical tabulation showing the storeroom issues to the various departments by types of commodities (food, supplies, clothing and hospital or laboratory supplies). These are automatically totaled and checked with the totals shown on the basic accounting report. Copies of this report are sent to the various department heads as well as to the administrative staff for their use in controlling departmental expenditures. This tabulation is also used as the basis for the monthly Food Cost Report for our institution which shows the daily ration cost by the various kitchens.

The basic Stores Inventory Cards are next sorted by commodity number, and a tabulation is made monthly showing the total quantity issued by each storeroom and the cost of these various items. Copies of this tabulation are sent to the administrative staff and to the storeroom managers for use as a guide in future buying.

This tabulation is also used to prepare a monthly report on the quantity of meats, produce and fresh fruits used (all on a pound basis) and the processing or preparation loss sustained on each of the items. This, of course, enables the storeroom managers to keep a close check on the preparation of these items as well as the quality and grade when ordering.

Our records are subject to an annual audit by the Legislative Joint Auditing Committee. To facilitate this, the Master Card Files are used by the IBM Department to prepare the skeleton forms on which the storeroom inventories are taken, whether during or at the close of the fiscal year. Since several hundred items are carried in stock at each storeroom, arranged as far as possible to conform with the alphabetical commodity sequence, this results in a substantial saving of time, effort and money for this operation alone.

PRELIMINARY PROGRAM TOPICS FOR NINTH MENTAL HOSPITAL INSTITUTE

Hotel Cleveland, Cleveland, Ohio, September 30th through October 3rd, 1957

MONDAY, SEPTEMBER 30th

LAYING THE FOUNDATIONS FOR AN OPEN MENTAL HOSPITAL: Administrative, community and cultural attitudes will affect its development. Ultimately it will flourish best in a community which takes responsibility for a total mental health program. Educating staff and community into accepting this viewpoint is the task of administration.

Francis J. O'Neill, M.D.

Central Islip State Hospital, New York

NEW TYPES OF HOSPITAL-COMMUNITY FACILITIES: To be effective, the open hospital should be supported by peripheral services—day and night hospital care; half-way houses; therapeutic farms; geriatric hospitals; clinics; and psychiatric units in general hospitals. As these facilities are developed community participation will result.

Leader to be announced

LEGAL IMPLICATIONS OF THE OPEN HOSPITAL: Modern hospital psychiatry demands that the administrator take some calculated risks. He must meet the dual responsibility of protecting the public and the patient, while providing a non-authoritarian therapeutic environment.

Henry A. Davidson, M.D.

Overbrook County Hospital
Cedar Grove, New Jersey

LOCAL PUBLIC HEALTH SERVICES AND THE HOSPITAL: An effective open hospital will not only utilize all the Public Health and other facilities of the community, but will feed back its own services in return. Examples are the use of the Public Health Nurse to visit patients in the hospital and to contact and follow up discharged patients; the use of the hospital staff by Public Health agencies in, for instance, industrial psychiatry programs, accident prevention, control of alcoholism and the psychiatric aspect of maternal and child health.

Robert H. Felix, M.D., N.I.M.H., Bethesda, Md.

TUESDAY, OCTOBER 1st

COMMITMENT LAWS ARE IN URGENT NEED OF REVISION: In many states existing laws and forms do not begin to reflect modern psychiatric principles. Methods must be devised to assist legislators to enact practical workable procedures.

Leader to be announced

ACADEMIC LECTURE

PRINCIPLES, SKILLS AND TOOLS OF SCIENTIFIC MANAGEMENT

Professor James L. Hayes

Department of Business Administration
St. Bonaventure University, New York

MANAGEMENT PRINCIPLES APPLIED TO THE MENTAL HOSPITAL: The application of the principles of scientific management to the specific organization in the mental hospital. Including communications; delegation of authority; lines of relationship; authoritarian versus democratic organization; interpersonal relations; need for organizational structure; and job qualifications and training of supervisors.

Lee G. Sewall, M.D.

VA Hospital, Perry Point, Md.

THE FALLACY OF THE PER DIEM: How can the public be expected to evaluate our real financial needs unless we can give an honest cost accounting of our various services? Many administrators fail to take into account such variables as the value of patient and volunteer services; family contributions; prison labor and Federal surplus commodities. There is need for a non-medical audit of all hospital services.

John J. Blasko, M.D.

Commissioner Mental Health
Hartford, Conn.

WEDNESDAY, OCTOBER 2nd

INVOLVING COMMUNITY PHYSICIANS IN PSYCHIATRIC FACILITIES: Through state and county medical societies, specialists and "family doctors" can provide a new core of medical services within the hospital, and eventually develop into key community supporters. Professional incentives offered should include staff appointments, orientation courses, involvement in staff conferences and feed-back of clinical information.

Robert A. Matthews, M.D.

Commissioner Mental Health
Harrisburg, Pa.

ADMINISTRATION OF RESIDENTIAL UNITS FOR CHILDREN: Discussion of the need for specially trained, flexible and tolerant personnel; methods of establishing liaison with community services; and type of plant, its location and the costs of such a unit.

Thaddeus P. Krush, M.D.

University of Nebraska College of Medicine, Omaha

HOW THE SOCIAL GROUP WORKER MAKES INSTITUTIONAL LIFE MORE THERAPEUTIC: By working directly with patients and relatives, he helps individuals and groups to make use of social group experiences as part of their therapeutic program and in preparation for return to the community. He serves as staff consultant on problems relating to institutional group living. What specific skills and knowledge does he use?

Mr. Raymond Fisher, Assoc. Prof. Soc. Work
Western Reserve Univ., Cleveland, Ohio

MANAGEMENT OF THE GERIATRIC PATIENT: Constructive community programs for the care of aged patients are essential to avoid unnecessary commitment

to the mental hospital. These should result from a joint endeavor between hospital and community agencies.

Maurice E. Linden, M.D., Mental Health Div.
Dept. Public Health, Philadelphia, Pa.

IMPROVED COMMUNICATIONS BETWEEN HOSPITAL STAFF AND ARCHITECTS AND CONTRACTORS: Communication between hospital, architects and contractors has produced disappointing results in the past. There must be mutual understanding of, on the one hand, the medical program, the patients' needs for privacy, protection, sociability and comfort, and on the other, of limitations of space relationships, materials and costs.

Mr. Clarkson Hill, Business Administrator
The Institute of Living, Hartford, Conn.

INVENTORY CONTROLS AND WAREHOUSING: Intelligent controls and centralized records are vital in the area of supplies and equipment. Good inventorying demands centralization, centralization requires warehousing. By-products are improved purchasing methods, standardization of requisition, better interdepartmental cooperation and improved employee relations.

Mr. William Brenizer, Business Administrator
State Hospital, Richmond, Indiana

THE SPECIFIC FUNCTIONS OF THE PSYCHIATRIC NURSE: A discussion of her overall role in the treatment of the patient; what the psychiatrist wishes from her; how she can meet the patients' needs; the importance of her role as ward administrator in a psychiatric hospital.

Ewald W. Busse, M.D.
Duke University, Durham, N. C.

THURSDAY, OCTOBER 3rd

THE ROLE OF THE PRIVATE PSYCHIATRIC HOSPITAL: Private psychiatric hospitals have less than 3% of the total mental hospital beds, yet they account for 42% of the annual admissions to all mental hospitals. Improved communication between public and private hospitals would provide prompt exchange of services and facilities, and forge one more link in the chain of community acceptance.

Philip B. Reed, M.D.
Norways Foundation, Indianapolis, Ind.

MENTAL DEFICIENCY: A PSYCHIATRIC PROBLEM: Reduction of infant mortality, saving of premature births and improved diagnostic procedures contribute to a changing pattern of admissions, attitudes, management and therapy of these patients. Prompt recognition and appropriate psychotherapy need a competent psychiatric approach. New research monies can help solve many problems if inquiries are instigated by positive medical investigation.

Leader to be announced

THE IMPORTANCE OF SANITATION IN THE HOSPITAL: Sanitation is both a management and a treatment function; it affects housekeeping, maintenance, laundry operation, food service, plumbing, water supply and many other basic services.

Mr. Robert Seaman, Business Administrator
State Hospital #1, Fulton, Mo.

INFORMATION ABOUT THE INSTITUTE

As this issue of MENTAL HOSPITALS goes to press, the program for the Ninth Mental Hospital Institute, to be held at the Hotel Cleveland, Cleveland, Ohio, from September 30th through October 3rd, 1957, is nearing completion. The Registration Form and the final program topics, with the names of the Discussion Leaders, will be sent out as the Supplementary Mailing for June.

With the Registration Form this year will come a reply-paid, addressed postcard on which to reserve your hotel accommodation. The Hotel Cleveland will send your confirmation direct. Please note, however, that it is also necessary for you to send the completed Registration Form to Mental Hospital Service. The hotel reservation card must be received by the Hotel Cleveland and the Registration Form by Mental Hospital Service not later than September 16th.

Dr. Robert S. Garber, of the New Jersey Neuro-Psychiatric Institute, has been this year's energetic and creative Program Chairman, assisted by Dr. Cecil L. Wittson, of the Nebraska Neuropsychiatric Institute, Dr. Charles A. Roberts, Dept. of National Health and Welfare, Ottawa, and Mr. Clarkson Hill, of the Institute of Living, Hartford, Conn. Mr. Hill acted as liaison between the Program Committee and the business managers to help develop interesting and important business topics for the Institute Program, and also to plan the discussion for the private meeting of hospital business managers to be held the Sunday preceding the Institute in the Hotel Cleveland.

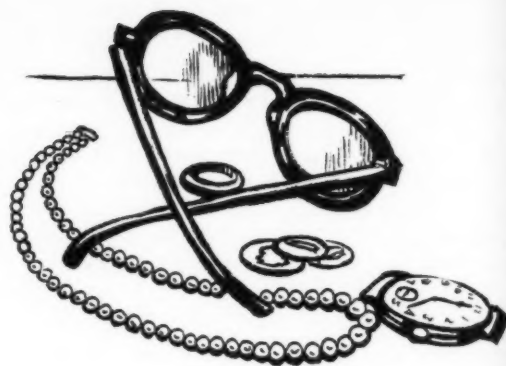
Members of the Local Arrangements Committee for the Ninth Institute are Drs. Harrison Evans and Douglas Bond, Co-Chairmen, with Drs. Ewing Cawfis, Guy Williams, William Grover, Edward Hinko, Louis Karnosh, Jack Nichols, David Sprague and Mr. Sam Whitman.

Space in the hotel is available all day Sunday for other private meetings by special interest groups, such as Commissioners of Mental Health and any others who wish to avail themselves of these facilities. Arrangements to reserve the space should be made as early as possible with Mrs. Phyllis Woodward, of Mental Hospital Service, who handles administrative aspects of the Institute.

On Tuesday evening, October 1st, at 8 p.m., there will be another Optional Meeting conducted by Dr. James M. Cunningham, Superintendent of the new Children's Psychiatric Hospital being built at Dayton, Ohio. Dr. L. P. Ristine, the Commissioner of Mental Hygiene, will also be present. Slides of the hospital plans will be shown and Drs. Ristine and Cunningham hope to have a lively discussion of the issues centering around site selection and hospital design inherent in providing space for the diagnosis, treatment, care and research which make up the projected program for disturbed children. The present plans call for one hundred beds for children under eighteen, facilities for day treatment of a further fifty, and a Community Child Guidance Clinic which is to function as the outpatient department of the hospital. This is the first of four children's hospitals to be built out of the bond issue floated in Ohio to provide for mental hospital construction.

CARE OF THE PATIENT'S PERSONAL EFFECTS AND CLOTHING

By ALEXIS TARUMIANZ, Business Administrator
Delaware State Hospital, Farnhurst



ADMISSIONS TO THE DELAWARE State Hospital are of three familiar types; voluntary, committed and returns from trial visits. In all cases a single admitting practice is followed with respect to the patient's personal effects and articles of clothing.

The patient is brought to the central admitting room where an admitting nurse advises both patient and relatives of the hospital's admissions procedures. At this point, all personal effects are listed on a special admission form provided for that purpose. This form requires the separate listing of all effects under five categories, namely:

- (1) Valuables such as watches, jewelry, wallets and important papers or cards.
- (2) Cash, checks, bonds, negotiables.
- (3) Articles given to and signed for by a relative or member of family by the admitting nurse, who feels that the articles in question will be of no possible use to the patient. These items are usually of little intrinsic value and should be returned to the patient's home. However, this disposition might include a fur coat and the responsibility of the relative signing the form assumes great importance. If the patient is not accompanied by family members, such articles are listed and stored in a special locked room provided for that purpose.
- (4) Articles such as eyeglasses, dentures, cosmetics are sent to the

patient's ward when assignment is made.

- (5) Items of clothing, or suitcases, are sent from the ward to the Central Clothing Room. Large canvas bags are used for conveyance of personal clothing.

Once the patient's belongings are broken down into these five categories, control of *distribution* becomes vitally important. The admitting form tells, on paper, what the patient brought but only the third category is an open and shut transaction.

Valuables are inserted in a sturdy pre-printed deposit envelope, on which the contents are listed; the envelope is dated and signed by the admitting nurse and the patient or responsible relative. The envelope flap is sealed and it is sent to a central reception office where it is recorded in a journal by patient's name; the date and contents are included in the register. The sealed envelope is then stored in a locked steel cabinet until legitimately withdrawn on the patient's discharge.

Cash, Clothing & Personal Effects Handled Separately

Cash, checks, bonds are sent promptly to the cashier's office. Cash is deposited to a trust fund set up to cover the patient's personal expenses. Checks and bonds are deposited to principal trust under care of the Finance Officer, who alone may determine future disposition. Receipts are issued for any amounts received and these receipts are stapled to the pa-

tient's admission form to become a part of his records when filed.

Articles for personal grooming, dentures and eyeglasses, which are sent to the wards, are in turn listed on a ward admitting form. This form advises the charge nurse of the items recorded as sent to her ward with the new patient. Their safekeeping becomes a ward function and her responsibility.

Items of clothing and suitcases present no special problem. The Central Clothing Room receives all the patient's personal clothing and suitcases immediately after ward assignment is made. Suitcases are tagged with the patient's name and sent back to the newer wards for storage. In cases of a few older wards where facilities are crowded, suitcase storage is made by the clothing supply personnel in specially designated rooms. Clothing is marked by name and ward and entered as personal issue on the patient's clothing issue sheet. All sizes are recorded on these sheets. Within twenty-four hours the clothing received is returned to the patient's ward. If insufficient clothing has been brought by the patient, the clothing room will complete his issue from supply. Later, as other clothing needs arise the patient will be brought to the Clothing Room for measurement and fitting. If this is not possible, clothing supply personnel will visit the patient on the ward. Our recommended clothing standard prescribes four changes of clothing for each ambulatory patient.

THE
san
hospit
operat
can u
cialist
whose
ence l
know
an un
can n
goal
fect s
tion
throu
nanc
divor
signm
to the
perin
Re
minis
tals t
tions
tion
and l
tions
fied
meet
the I
they
an o
retru
Heal
Heal
lic H
wide
train
one
cent
offer
tary

In
duti
with
and
sanit

Mental Hospital Sanitation

By E. CALVIN MOORE, M.D., Assistant Medical Director

and WALTER C. BAKER, Sanitarian,

New Jersey Neuro-Psychiatric Institute, Princeton

THE MAINTENANCE of proper sanitation standards in a mental hospital is certainly one phase of the operation where the administrator can use the advice and help of a specialist. A qualified Sanitation Officer, whose formal education and experience have equipped him with specific knowledge of sanitary procedures and an understanding of their purposes can not only contribute directly to the goal of patient care, but can help effect such economies as the preservation of material and equipment through sanitary storage and maintenance methods. Ideally he should be divorced from any departmental assignment and be directly responsible to the superintendent or assistant superintendent.

Recognition of the need led the administrators of the New Jersey hospitals to ask the Department of Institutions and Agencies to set up the position of Sanitarian. This was in 1953 and by 1956, seven of the nine positions established were filled by qualified men. These men are required to meet the licensure requirements of the Department of Health; to do so they must have had experience with an official health agency. Most were recruited through the Department of Health itself and the U. S. Public Health Service. (Indeed, the title Public Health Sanitarian is rather more widely used in other states.) Academic training is preferred with a major in one of the biological sciences. In recent years some colleges have started offering a general curriculum in sanitation sciences.

Duties of the Sanitarian

In urban hospitals, the principal duties of a sanitarian are associated with the handling and storage of food and milk; dish-washing; building sanitation; housekeeping techniques

and materials; linen storage and distribution; laundry operation; sterilization and storage of utensils; plumbing defects; infectious wastes disposal; isolation of communicable diseases; disinfection; garbage and trash storage and disposal; and insect and rodent control.

When the hospital is located in a rural area, other functions are included. Some of these are the treatment of water and sewage; dairy, piggery and abattoir sanitation; the disposal of trash and garbage and the control of noxious weeds.

Food Service Sanitation

The hospital operation which is probably most continuously threatened by contamination is the food service—from the storage of purchased or home-grown foods to the washing of dishes after the meal. In no other area are inadequate sanitary measures more likely to lead to malaise or serious illness in a large segment of the patient population. Assuming that purchased foods are delivered in a safe condition, there are the problems of storage, handling before and after preparation, and serving. At institutions which grow their own vegetable crops, and raise and slaughter animals, surveillance must begin even prior to delivery. A sanitation officer whose authority stems directly from top administration is uniquely able to follow the handling of foods under separate departmental authorities from harvest to consumption.

One of the fundamental sanitary needs in this service is the provision of adequate toilet facilities. These must be conveniently located, but not immediately adjacent to food preparation areas. The supervisory personnel are not always alert to the requirement that all food handlers carefully wash and dry their hands after using

the toilet. The sanitarian cannot guarantee this, but he can make the practice easy and convenient by ensuring that an adequate supply of soap and hand towels is available. By instruction, he can help all food handlers to understand the reason for this hygienic measure.

One of the food storage problems arises from budgetary restrictions which require patients to be adequately fed for a per capita sum approximately equal to the cost of the table scraps fed to the family dog or thrown into the garbage can of many American families. Obviously one must use "left-overs", the handling, storage and re-serving of which must be carefully supervised.

Whether patients are fed in a central dining-room, a small ward or in a special building, it is important that dishes, tableware and food be adequately protected prior to the actual serving. Not infrequently butter, bread and even milk are placed on the table too far in advance of their use to protect them against contamination.

The need for vigilance does not cease even when the meal is safely eaten! There is still the problem of cleaning and storing dishes and utensils. Some administrators, having installed automatic dishwashing apparatus, believe they need not concern themselves further. But there is still the need for the proper stacking of dishes in the racks so that they are reached by detergents. Is the dishwater temperature being properly maintained? Is the gauge temperature frequently read and is it correct? The temperature of the water delivered should be periodically checked by the direct reading of a thermometer. Especially in areas with water of high mineral content there is a tendency for spray nozzles to become clogged

by deposits, resulting in inadequate delivery of wash water to the dish surfaces. How often are mechanical dishwashers routinely checked for this simple and obvious source of failure?

In some machines the tray of dishes is moved by hand. Does the employee responsible understand why proper time exposures are necessary in the washing, rinsing and sterilizing phases of the process? In other machines, this operation is mechanical—but is this part of the apparatus working satisfactorily? Finally, when the dishes are delivered gleaming but still covered with droplets of water, does the employee yield to the temptation of using a not-too clean dish towel to hasten the drying process and thus defeat the effect of sterilization—or has he been instructed about the safety advantage of air-dried above towel-dried dishes? Once clean and dry, are the dishes stacked properly in an area where they are not subject to further contamination—by hands which have been adequately cleaned?

Sanitation Problems in Housekeeping

The maintenance of patient living-areas in an adequately sanitary condition requires daily and constant supervision by some responsible and interested person. While this is not part of the sanitarian's duties, he can detect a breakdown in maintenance by periodic inspection. He can indoctrinate attendant and nursing personnel in, for instance, the proper handling of infectious waste. Dressings contaminated with purulent material can be a source of infection to the unsuspecting person who delivers them to the incinerator. If such material is improperly wrapped, flies will rapidly disseminate infectious organisms.

The sanitation officer should report to the nurse if he finds unlocked and unsupervised medicine cabinets. He can also advise as to the proper selection of detergents, disinfectants and deodorants. A concentrated disinfectant, which requires dilution to the proper usage strength saves shipping costs, but calls for subsequent bottling into usable strength with a measuring dispenser. It is necessary in the beginning and wise at regular intervals for the sanitarian to impress upon ward personnel the need for care in this simple process of dilution. Periodic

checking ensures frequent changes of wash water and the proper storage and airing of sponges, brushes and mops.

In his tours of the hospital, it is not uncommon for the sanitarian to find rubber hoses temporarily connected to faucets in a fashion subject to back-siphonage. Such an occurrence can provide dramatic teaching material as the sanitarian explains to employees how such a practice can dangerously contaminate the entire water supply of the hospital.

Sanitary Water Supplies

In rural institutions, there is the problem of potable water. When the source of supply is a surface water, someone must be aware of the problems of watershed management as it might affect the institution. If a reservoir is involved, its management must be sanitary. Modern conservation also impels the use of ponds or lakes for fishing and boating, as well as for providing drinking water. The sanitation officer must be watchful for the development of excess algae and make appropriate recommendations for its control which will not be detrimental to the fish potential.

In an institution which maintains its own water purification plant, the sanitarian must be familiar with the flocculation, filtration and chlorination functions of the plant. It is especially important for him to provide frequent assays on the chlorine residual of the water delivered by the plant and in the more distal lines.

Approximately 75% of the water provided for hospital use is returned as sewage. Adequate treatment of sewage must be effected so that the effluent discharged by the sewage treatment plant will not violate the riparian rights of owners downstream, or contaminate water that may be taken by a community for drinking purposes. Fortunately there is increasing legislation concerning stream pollution and such legislation requires that adequate records be maintained by the institution as to the chlorine residual, biochemical oxygen demand, and volume of organic matter discharged into streams by the sewage treatment plant. The sanitarian is instrumental in seeing that such records are properly taken and maintained by the sewage treatment plant operator.

Rodent and Insect Control

Mice are often introduced into the hospital as inhabitants of the numerous boxes and cartons constantly received. If food and harborage are available, the mouse population will quickly increase. The control of these unwanted guests is a matter of special concern. Mice and rats are a direct threat to health; they transmit salmonella organisms by fecal contamination of foods and are also associated with the transmission of some rickettsial and spirochetal disease organisms. They account for enormous losses of stored grains and other dried products and, if the population is high, they will be outright in their destruction of wood and masonry.

Lacking a Pied Piper, trapping is a valuable procedure in selected instances, but for general control the sanitation officer will resort to appropriate rodenticides. The selection of an agent must be based, not only upon its lethal effect on rodents, but also upon its relative toxicity to man. Of the less toxic rodenticides, Red Squill, Warfarin and Pivaline are the most commonly used; of these, Warfarin has been to date the rodenticide of choice. It proves lethal by its anticoagulant activity in the blood stream, in a fashion similar to Dicumarol; it is slow acting and requires successive feedings for five to seven days to be effective. Pivaline acts similarly and is gaining in popularity because it has the added advantage of being effective against some insects. But all such preparations are potentially hazardous to man and domestic animals and their use in a mental hospital should be under the most careful supervision.

The Ubiquitous Fly

If mice love grain barns, flies love dairies, but in recent years effective fly control has been maintained both by good sanitation and the treatment of ceilings, walls, stanchions, etc. with the residual type chlorinated hydrocarbon sprays. However, the instinct for survival led nature to develop a "resistant fly" and the weary dairymen reverted to daily or twice daily fogging with pyrethrum at a cost of \$2.50 per gallon. By awareness of entomological developments, however, sanitarians were able to recommend instead the use of an organophosphate

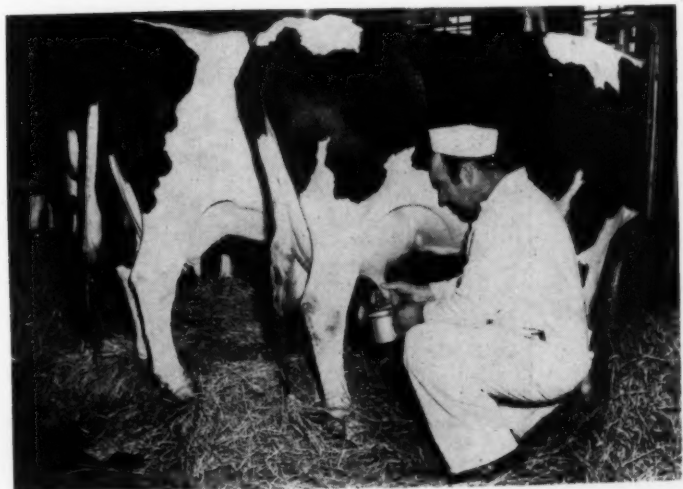
Sanitation Practices at the Neuro-Psychiatric Institute

Photos by Wm. M. Morrison



Foods under refrigeration are covered to prevent contamination by airborne particles. Jars on second shelf contain samples of food served in preceding 24 hours; they may serve to absolve the dietary department should disorders suggestive of food poisoning occur at the hospital.

Put away that towel! Too often the temptation to speed up the drying process by towel only makes the dishes less clean and sterile. Dishes properly scraped, stacked, washed in water containing a good dishwashing compound, and rinsed and sterilized in 180° F. water need no toweling.



Health Precaution: Passing the first three or four streams from each teat through the fine mesh of a strip-cup detects stringiness in the milk, which indicates an infection in the udder; the organism causing the infection may also affect man. This practice also keeps the bacterial count of the raw milk supply lower, since the first few streams usually contain large numbers of bacteria.

insecticide that was relatively non-toxic to warm-blooded animals, plus a new technique of application that involved only the use of a treated cord strung across the ceiling of the barn. One treatment of the cord is effective for an entire season at a cost of one dollar for the insecticide, plus string and one man-day of labor.

Flies are sometimes excessive in patient areas. Fogging was obviously unsatisfactory here too. But a residual type of insecticide applied to the upper walls and ceilings of entrance porches, vestibules and selected rooms controlled the invasion, because flies come to rest in the upper areas of an enclosure. After fifteen or twenty minutes in contact with these treated surfaces, the fly absorbs a lethal dose. Continuous fly control can thus be effected by one or at the most two treatments a year.

Another Sanitary Problem—the Dairy

Though milk may be an "ideal food" it is also an ideal culture medium for pathogenic bacteria. Responsibility for dairy hygiene is added unto the sanitarian if he works in a hospital which maintains one. How often is the milk-producing herd tested by qualified veterinarians? he will ask. Do the herdsmen and the dairymen understand the importance of sanitation in the milking barn? Is the milking equipment properly sterilized before use? If pasteurization is carried on (and it should be) it is important to make certain that proper temperature and time exposure is maintained. Do the employees who perform this vital task understand the necessity for and methods of proper pasteurization? Storage of milk at a low temperature is of the utmost importance in maintaining a low bacterial count. How many institutions periodically check the temperature of the milk when it is delivered to the consumer?

Some institutions have installed automatic "bottling" equipment, and have been chagrined to discover that the bacterial count in their milk has increased! Such equipment can only be of value to the extent that it is properly cleansed and maintained. There can be no laxity at any point in the handling of milk. Frequent bacteriological analyses of milk samples are the best method of maintaining continuous sanitary practices.

Garbage and Trash Disposal

Garbage and trash storage is a frequent offender against good sanitary practices. Here again the sanitation officer can see that the garbageman fully understands the reasoning behind certain administrative edicts. Spillage, he will explain, attracts insects and creates odors. Papers are a fire hazard. Rough handling of containers mis-shapes receptacles and lids, giving free access to insects and emitting odors. (The application of residual type insecticides can be useful.)

Most mental hospitals, being rural or semi-rural, have a problem of ultimate garbage disposal. Open dumping and burning is rightly prohibited in many states. The sanitary land-fill is usually the chosen method, and this task is left to farm personnel, who are frequently unaware of the importance of quick covering of deposited wastes, and thus manage to defeat the purpose of the entire operation. If the hospital maintains a piggery, edible garbage has to be separated and used for feeding. It must be stored at low temperatures until it is available for adequate sterilization for the prevention of trichinosis. An improperly managed piggery can contribute immeasurably to the fly control problem. Again, we will find the conscientious sanitarian checking garbage cans, land-fill and piggery.

Depending upon his individual background he may also be found contributing to the program of industrial hygiene and safety. Frequently his specific knowledge of epidemiology, air pollution and general insect control can be most useful. It is not inconceivable that in future the sanitarian may be a valuable member of radiological monitoring teams. With the increasing use of radioactive isotopes in experimental and therapeutic medicine there is an increasing need for radiological safety programs and the disposal of radioactive wastes. The sanitation officer also has a big part to play in a civil defense and disaster program.

The effectiveness of the sanitation officer will be no greater than his ability to elicit intelligent cooperation from the employees whose work he must examine with a critical eye. The very nature of his duties is such that he is compelled to discover the

shortcomings and omissions of workers in various hospital departments. To the short-sighted, he may appear to be in conflict with the goals of the various department heads, who are responsible for the operations he examines so critically. The way he handles his interpersonal relationships will be of the utmost importance.

Value of Sanitation Seminars— for Supervisors Too

By 1956 the seven sanitarians in the New Jersey hospital system felt the need to become better acquainted with the many new developments in their field which would benefit their institutions. Accordingly the hospital administrators requested the Department to set up a thirty-day course in the fundamentals of sanitation as they apply to hospital operation. At the suggestion of the sanitarians, hospital supervisory personnel were invited to participate. The Department cooperated enthusiastically, and the U. S. Public Health Service provided a group of excellent instructors. Our hospital, where the suggestion had originated, provided meals and accommodation for participants from other hospitals.

The course was divided into 15 weekly sessions of two days each, to avoid too much interruption of routine duties. It consisted of lectures and field exercises. The subjects were elementary bacteriology, epidemiology and communicable diseases; water, sewage; plumbing; refuse and garbage; hospital and ward sanitation; industrial hygiene; noxious weed control; insect and rodent control; milk; food—including meat, poultry, shellfish, frozen and canned foods; restaurant equipment; sanitizers; and bakery sanitation.

The course, as well as stimulating the sanitarians themselves, gave supervisory personnel a better knowledge of the reasons for sanitary practices. The presence of outside experts providing information in formal classes gave weight to the importance of the subject. In each institution the sanitarian felt he had gained several on-the-job assistants who could participate in the development and practice of sanitation with a knowledge, interest and enthusiasm which had previously been lacking.